

GOVERNMENT OF GUAM

And

TOKIO MARINE PACIFIC INSURANCE, LIMITED

GOVGUAM RETIREE SUPPLEMENT INSURANCE AGREEMENT

October 1, 2017 – September 30, 2018

Preamble

This Agreement is made effective by and between the GOVERNMENT OF GUAM ("GovGuam") and Tokio Marine Pacific Insurance, Limited ("Company"). The effective date of this Agreement is October 01, 2017.

Recitals

WHEREAS, Company is an insurance company duly licensed to do business in Guam; and

WHEREAS, Company is qualified to provide an insurance program designed for eligible GovGuam retirees spouses and survivors to supplement Medicare; and

WHEREAS, GovGuam selected Company to provide this insurance program to eligible GovGuam retired employees, spouses and survivors of retired employees who receive annuity benefits; and

WHEREAS, Company agrees to administer this insurance program, as hereinafter set forth, under a health insurance plan known as the "GovGuam Retiree Supplement Plan", and

WHEREAS, the parties wish to enter into an agreement defining their mutual rights and obligations.

NOW, THEREFORE, in consideration of the premises, mutual promises and covenants contained herein and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties agree as follows:

ARTICLE 1

Preamble and Recitals

The preamble and recitals set forth above are hereby incorporated into and made a part of this Agreement.

ARTICLE 2

General Provisions

§2.1 **Definitions:** The following words and phrases shall have the following meanings, unless a different meaning is required by the context. Words in the singular shall include the plural unless the context indicates otherwise. These are general definitions and are not an indication of the existence of a benefit. The definitions shall control the interpretation of this Agreement, Enrollment forms, any identification cards, any supplements and the performance hereunder, unless the term is otherwise specifically defined or modified within a particular section of this Agreement, or defined in the attached Exhibits hereto.

2.1.1 **Accident:** Shall be defined as an event that is sudden and not foreseen, is exact as to time and place and which results in bodily injury.

2.1.2 **Administrative Service Office:** Shall be defined as the Company or an agent appointed by

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Company which is directly responsible for administrative procedures and for the processing and payment of Provider claims on behalf of Covered Persons. Calvo's Insurance Underwriters, Inc. shall be the Administrative Office until otherwise notified in writing by Company.

2.1.3 **Agreement:** Shall be defined as the GovGuam Retiree Supplement Plan Agreement, an employee-sponsored plan, including the attached Group Health Certificate and Exhibits made a part hereof.

2.1.4 **Ambulatory Surgical Center and/or Surgicenter:** Shall be defined as a legally operated institution or facility, either freestanding or part of a Hospital with permanent facilities, which a patient is admitted to and discharged from within a 24-hour period and which:

2.1.4.1 has continuous Physician and Nursing services whenever a patient is in the facility; and

2.1.4.2 has permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures; and

2.1.4.3 is not a private office or clinic maintained by a Physician for the practice of medicine or dentistry or for the primary purpose of performing terminations of Pregnancy.

2.1.5 **Anesthesia Services:** Shall be defined as the administration of anesthetics to achieve general or regional anesthesia and related resuscitative procedures.

2.1.6 **Case Management:** Shall be defined as a process directed at coordinating resources and creating flexible, cost-effective options for catastrophically or chronically ill or injured individuals on a case by case basis to facilitate quality individualized treatment goals and improve functional outcomes. Case Management also includes providing any alternative medical or non-medical benefits to a Covered Person that are expected to be medically beneficial for the Covered Person but which may not be Covered Services under this Agreement. Services should be cost-effective and generally follow acceptable standards of evidence based medical practice. The Company may, in its discretion, provide said alternative benefits for a Covered Person's Illness or Injury in lieu of, or in addition to, Covered Services if:

2.1.6.1 The total cost of said alternative benefits does not exceed the total benefits payable for Covered Services;

2.1.6.2 The Covered Person's Physician recommends that the Covered Person receive said alternative benefits;

2.1.6.3 The Covered Person's Physician agrees that the recommended alternative benefits are expected to be beneficial for the treatment of the Illness or Injury; and

2.1.6.4 The services are prior authorized by the Company's Medical Management Department.

2.1.7 **Certificate:** Shall be defined as the GovGuam Retiree Supplement Plan Certificate attached hereto.

2.1.8 **Chemotherapy:** Shall be defined as remedial Services of a euplastic Illness or tumor by means of systemic cytotoxic agents or systemic hormonal agents.

2.1.9 **Chemical Dependency:** The pathological use or abuse of alcohol or other drugs in a manner, or to a degree, that produces an impairment in personal, social or occupational functioning and which may, but need not, include a pattern of tolerance and withdrawal.

2.1.10 **Cosmetic Procedure or Surgery:** Shall be defined as Services performed solely for the improvement of a Covered Person's appearance rather than for the improvement, restoration or correction of normal body

functions.

2.1.11 **Covered Dependent:** Shall be defined as a Dependent eligible to receive benefits under the terms of this Plan.

2.1.12 **Covered Person:** Shall be defined as a person entitled to receive Covered Services pursuant to the Retiree Supplement Insurance Plan. A Covered Person shall reside in the Service Area, shall be a retiree of the Government of Guam, or a spouse of a retiree of the Government of Guam or a survivor of a retiree of the Government of Guam, and enrolled in Medicare Parts A & B, and eligible for Retiree Supplement Insurance Plan.

2.1.13 **Covered Services:** Shall be defined as Medically Necessary Services that are not specifically excluded from coverage by this Agreement and other Services which are specifically included.

2.1.14 **Dental Service:** Shall be defined as the act of:

2.1.14.1 adjusting, removing, or replacing teeth. The removing of wholly or partly unerupted impacted wisdom teeth shall be considered an oral surgical procedure; or

2.1.14.2 providing Services for teeth, gums, and related parts of the oral cavity; or

2.1.14.3 performing any other Services normally rendered by a Dentist.

2.1.15 **Dentist:** Dentist means a doctor of medical dentistry or dental surgery who is currently licensed to practice by the appropriate authority of the jurisdiction in which the person practices and who renders Services within the lawful scope of such license.

2.1.16 **Domicile:** Shall be defined as the place where a person has his or her true, fixed, and permanent home and principal establishment, and to which whenever that person is absent that person has the intention of returning. A person shall have only one domicile at a time.

2.1.17 **Durable Medical Equipment:** Shall be defined as equipment which is:

2.1.17.1 Able to withstand repeated use; and

2.1.17.2 Primarily and customarily used to serve an illness or injury; and

2.1.17.3 Not generally useful for a person in the absence of illness or injury.

2.1.18 **Eligible Charge(s):** Shall be defined as the portion of charges made to a Covered Person for Covered Services rendered which are payable to the Provider under this Agreement. For a Participating Provider, the Eligible Charges shall be the reimbursement amounts agreed to between the Company and the Participating Provider.

2.1.19 **Emergency:**

2.1.19.1 In general, an Emergency shall be defined as an Accidental Injury or an acute or serious medical condition of sudden or unexpected onset requiring immediate medical attention because any delay in treatment, in the opinion of the Physician, would seriously impair future treatment or result in permanent disability, a serious worsening of the condition, or irreparable harm to the Covered Person's health or endanger his or her life. Examples of Emergencies include, but are not limited to heart attack, severe hemorrhaging, loss of consciousness, convulsions and loss of respiration.

2.1.19.2 For purposes of compliance with the requirements of Section 2719A(b) of the PHSA, as added by PPACA, a PPACA Emergency shall mean an injury or medical condition

manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to place the health of an individual (including the health of a pregnant woman or her unborn child) in serious jeopardy, or to result in serious impairment to bodily functions or serious dysfunction of any bodily organ or part.

2.1.19.3 PPACA Emergency Services shall mean services provided by the emergency department of a Hospital, including a medical screening examination, and also including ancillary services routinely available to the emergency department to evaluate such condition, and such further medical examination and treatment to stabilize the Covered Person as are within the capabilities of the staff and facilities available at the hospital.

2.1.19.4 Co-Insurance percentages and Co-Payment amounts for any PPACA Emergency Services provided by Non-Participating Providers shall not be greater than such percentages or amounts that would be applied to Participating Providers. The Company's payments for any PPACA Emergency Service shall not be more than the greater of:

2.1.19.4.1 The amount negotiated with Participating Providers for the PPACA Emergency Service (excluding any Co-Insurance or Co-Payment normally charged the Covered Person for such service when provided by Participating Providers); or

2.1.19.4.2 The amount calculated using the same method the Company generally uses under this Agreement to determine payments for such services when provided by Non-Participating Providers, but excluding any Co-Insurance or Co-Payment normally charged the Covered Person for such service when provided by Participating Providers; or

2.1.19.4.3 The amount that would be paid under Medicare (Part A or Part B) for the PPACA Emergency service, excluding any Co-Insurance or Co-Payment normally charged the Covered Person for such service when provided by Participating Providers.

2.1.20 **Enrollment:** Shall be defined as the acceptance, as of a specified date, of a written application for coverage under the Plan on forms provided by the Company.

2.1.21 **Experimental:** Shall be defined as all procedures and treatments not covered under the Medicare Program (Title XVIII of Social Security Act of 1965, as amended), unless otherwise specifically included or excluded under this Agreement.

2.1.22 **HIPAA:** Shall be defined as the Health Insurance Portability and Accountability Act of 1996, as amended (including amendments by PPACA), including all provisions codified at 42 U.S.C. §300gg, and the regulations promulgated thereunder.

2.1.23 **Home Health Care Agency:** Shall be defined as a public or private agency or organization, or part of one, that primarily provides Home Health Care Services and complies with the following requirements:

2.1.23.1 Is legally qualified in the state or locality in which it operates;

2.1.23.2 Keeps clinical records on all patients;

2.1.23.3 Services are supervised by a Physician or Nurse; and

2.1.23.4 Services provided by the Home Health Care Agency are based on policies established by associated professionals, which include at least one Physician and one Nurse.

2.1.24 **Home Health Care Plan:** Shall be defined as a program of Home Health Care established and approved in writing by the Covered Person's Physician for the provision of Home Health Care Services. The Physician shall state that confinement to a Hospital or Skilled Nursing Facility would be Medically Necessary for the treatment of the Covered Person's Injury or Illness if the Home Health Care Plan is not provided.

2.1.25 **Home Health Care:** Shall be defined as the Services set forth below, subject to all other exclusions and limitations set forth in this Agreement:

2.1.25.1 Part-time or intermittent home nursing Services from or supervised by a registered Nurse or a licensed practical Nurse;

2.1.25.2 Part-time or intermittent home health aide Services;

2.1.25.3 Physical therapy; and

2.1.25.4 Medical supplies, drugs and medications prescribed by a Physician, and laboratory Services to the extent that they would have been covered if provided or performed in a Hospital or Skilled Nursing Facility.

2.1.25.5 be a Covered Service, Home Health Service shall:

2.1.25.5.1 replace a needed Hospital or Skilled Nursing Facility stay;

2.1.25.5.2 be for the care or treatment of a Covered Person's illness or injury;

2.1.25.5.3 be ordered in writing by the Covered Person's Physician; and

2.1.25.5.4 be provided in the Covered Person's home (permanent or temporary) by a properly licensed Home Health Care Agency.

2.1.26 **Hospice:** Shall be defined as a coordinated plan of home and/or Inpatient Services, which treats a Terminally Ill patient and his or her family as a unit, focusing on providing comfort rather than on curing an illness. The plan provides Services to meet the special needs of the family unit during the final stages of a Terminal Illness and during bereavement. These services may include physical care, counseling, drugs, equipment and supplies for the terminal illness and related condition(s). Services are provided by a team made up of trained medical personnel, homemakers and counselors. The team acts under an independent hospice administration and helps the family unit cope with physical, psychological, spiritual, social and economic stress. Hospice is generally provided in the home, is not limited to people with cancer, and must be approved as meeting established standards, including but not limited to compliance with any licensing requirements of Guam, and the benefit period begins on the date the attending physician certifies that a covered member is terminally ill.

2.1.27 **Hospital:** Shall be defined as a medical institution which is operated in accordance with the laws of the jurisdiction in which the Hospital is located. The Hospital must, on an Inpatient basis, be primarily engaged in providing diagnostic and therapeutic facilities for surgical and medical diagnosis, and treatment of injured and sick persons. These Services must be provided by or under the supervision of Physicians and the institution must continuously provide twenty-four (24) hours a day Nursing Service by Nurses.

2.1.27.1 A Hospital may include a psychiatric or tuberculosis facility which satisfies the above requirements.

2.1.27.2 Any institution which is, primarily, a place for rest, a place for the aged, or a nursing home shall not be considered a Hospital for purposes of this Agreement.

2.1.28 **Injury:** Shall be defined as a condition caused by Accidental means that results in damage to the Person's body independently of Illness and is a result of an unexpected slip, fall, blow or other violent external force. Injury shall also include a scenario that is not unexpected or not Accidental if it constitutes a PPACA Emergency.

2.1.29 **Illness:** Shall be defined as a bodily disorder, disease, physical sickness, Pregnancy, Mental or Nervous Condition or congenital abnormality.

2.1.30 **Inhalation Therapy:** Shall be defined as remedial Services for an Illness or Injury by means of intermittent positive pressure breathing equipment.

2.1.31 **Inpatient:** Shall be defined as a Covered Person admitted to a Hospital, Skilled Nursing Facility or Hospice for a condition requiring confinement.

2.1.32 **Care Unit:** Shall be defined as a section, unit or area of a Hospital that is designated as an intensive care unit by the Hospital and is reserved and operated exclusively for the purpose of providing Services for critically ill patients.

2.1.33 **Maximum Annual Benefit:** Shall be defined as those benefits payable under this Agreement that have annual maximum limits for each Covered Person as shown in Exhibit A and B.

2.1.34 **Medically Necessary or Medical Necessity:** Shall mean services or supplies which, under the provisions of this Agreement, are determined to be:

2.1.34.1 appropriate and necessary for the symptoms, diagnosis or treatment of the Injury or Illness or dental condition;

2.1.34.2 provided for the diagnosis or direct care and treatment of the Injury or Illness or dental condition;

2.1.34.3 within standards of good medical or dental practice within the organized medical or dental community;

2.1.34.4 not primarily for the convenience of the Covered Person or of any Provider providing Covered Services to the Covered Person;

2.1.34.5 an appropriate supply or level of service needed to provide safe and adequate care;

2.1.34.6 within the scope of the medical or dental specialty, education and training of the Provider;

2.1.34.7 provided in a setting consistent with the required level of care; or

2.1.34.8 preventative Services as provided in the Plan.

2.1.35 **Medicare:** Shall be defined as Title XVIII (Health Insurance for the Aged) of the Federal Social Security Act, which includes Part A, Hospital Insurance Benefits for the Aged; Part B, Supplementary Medical Insurance Benefits for the Aged; and Part C, miscellaneous provisions regarding both programs, and also including any subsequent changes or additions to those programs.

2.1.36 **Medicare Supplement Insurance:** Shall mean private health insurance designed to supplement Medicare, which is designed primarily as a supplement to reimbursements under Medicare for the hospital, medical or surgical

expenses of persons eligible for Medicare, and meeting standards established by Section 1882 of the Social Security Act (42 USC §1395ss).

2.1.37 Mental or Nervous Condition: Shall be defined as a condition which includes neurosis, psychoneurosis, psychopathy, or psychosis or disease of any kind, in a degree which subsequently impairs the Covered Person's economic or social functioning; and shall, as required by the Parity In Health Insurance For Mental Illness and Chemical Dependency Act, Title 22, Guam Code Annotated, Chapter 28, include the definition of Mental Illness contained in said Act; and shall include, as required, relevant definitions found in the Mental Health Parity Act of 1996, Public Law 104-204.

2.1.38 Network: Shall be defined as the network of Participating Providers. Network may also be referred to as Plan Network.

2.1.39 Nurse, Nursing, Nursing Services: Shall be defined as a registered graduate nurse (RN), a licensed vocational nurse (LVN), or licensed practical nurse (LPN) who has received specialized Nursing training and experience and is duly licensed to perform such Nursing Services by the state or regulatory agency responsible for such licensing in the jurisdiction in which the individual performs such Services.

2.1.40 Occupational Injury: Shall be defined as an Injury arising out of, or in the course of, employment.

2.1.41 Palliation Therapy: Shall be defined as patient and family centered care that optimizes the quality of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social and spiritual needs and facilitating patient autonomy, access to information and choice. Palliative care should be covered on an outpatient basis only.

2.1.42 Participating Providers, Non-Participating Providers, Providers and Network:

2.1.42.1 Providers shall be defined as health care providers who are duly licensed in their jurisdiction and acting within the scope of their license. Such term shall include, without limitation, Physicians, Hospitals, ancillary health Services facilities and ancillary health care providers.

2.1.42.2 Participating Providers shall be defined as Providers who: (i) have directly, or indirectly through Company's agreements with other networks, entered into an agreement with the Company to provide the Covered Services; and (ii) are assigned from time to time by the Company to participate in the Network or any other network of Company pursuant to this Agreement.

2.1.42.3 Payment of claims to Providers: Claims shall be paid based on the agreements that Company has with its providers whenever the services are rendered by a participating provider.

2.1.43 PHSA: Shall mean the Public Health Service Act provisions that are part of HIPAA (as defined above), some of which have been added to the PHSA by PPACA.

2.1.44 Physician: Shall be defined as a legally licensed medical doctor, Dentist, surgeon, chiropractor, osteopath, podiatrist (chiropracist), optometrist, or clinical Psychologist acting within the scope of his or her license. A Physician shall not include a medical resident, intern, fellow, Physician's assistant, social worker or master prepared therapist.

2.1.45 Physician's Services: Shall be defined as Medically Necessary professional Services provided by duly licensed Physicians including diagnosis, consultation, medical treatment, surgery, anesthesia, physical therapy, x-ray and laboratory services, diagnostic procedures such as electrocardiograms, electroencephalograms, and other services customarily provided by Physicians for patients. Experimental Services shall not be included within the scope of Physicians' Services.

2.1.45.1 **Primary Care Services.** Basic, routine or general health care services of individuals with common health problems and chronic illnesses that can be managed on an outpatient basis. Primary care is provided by primary care physicians, nurse practitioners, physician assistants and other mid-level practitioners.

2.1.45.2 **Specialist Care Services.** Services provided by a medical specialist to whom a patient has been referred, usually by a primary care provider.

2.1.46 **Physical Therapy:** Shall be defined as remedial Services for the treatment of an Injury or Illness by means of therapeutic massage and exercise; heat, light and sound waves; electrical stimulation; hydrotherapy; and manual traction.

2.1.47 **Plan:** Shall be defined as the GovGuam Retiree Supplement Insurance benefits provided in accordance with this Agreement.

2.1.48 **Plan Year:** Shall be defined as the twelve (12) month period during which GovGuam Retiree Supplement Insurance benefits are provided under this Agreement.

2.1.49 **PPACA:** Shall mean the Patient Protection and Affordable Care Act of 2010, as amended.

2.1.50 **PPACA Preventative Care Services:** Shall mean care required by Section 2713 of the PHSA, as added by PPACA, to be provided without cost-sharing.

2.1.50.1 **Care considered PPACA Preventative Care shall be:**

2.1.50.1.1 Evidence-based items or services that have in effect a rating of A or B in the most recently updated recommendations of the United States Preventive Services Task Force ("USPSTF") with respect to the individual involved, except that 2009 USPSTF recommendations regarding breast cancer screening, mammography, and prevention issued in or around November 2009 shall not be considered current for purposes of this provision; and

2.1.50.1.2 With respect to women, any additional evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the HRSA.

2.1.51 **Preferred Drug Formulary:** Shall be defined as those medications chosen by the Company for their safety, effectiveness and affordability. The Preferred Drug Formulary is subject to change during the Plan Year.

2.1.52 **Preferred Provider (Center of Excellence):** Preferred Provider shall be defined as a Participating Provider that is a Hospital or Ambulatory Surgical Center located outside of the Service Area. The Hospital or Ambulatory Surgical Center shall be a Participating Provider at the time Services are rendered to the Covered Person and shall be specifically designated by name as a Preferred Provider in the more recent of Company's most current member brochure or Company's most current updated provider directory.

2.1.53 **Premium:** Shall be defined as the dollar amount paid to the Company for the provision of this Plan to Covered Persons.

2.1.54 **Psychiatric Services or Psychoanalytical Care:** Shall be defined as Services provided for the treatment of a Mental or Nervous Condition.

2.1.55 **Psychologist:** Shall be defined as an individual holding the degree of Ph.D., licensed as a psychologist in the jurisdiction in which services are provided, and acting within the scope of his or her license.

2.1.56 **Registered Bed Patient:** Shall be defined as a Covered Person who has been admitted to a Hospital or a Skilled Nursing Facility or a Hospice upon the recommendation of a Physician for any Injury or Illness covered by this Agreement and who is confined by the Hospital, Skilled Nursing Facility or Hospice as an Inpatient.

2.1.57 **Room and Board:** Shall be defined as all charges, by whatever name called, which are made by a Hospital, Hospice, or Skilled Nursing Facility as a condition of providing Inpatient Services. Such charges do not include the professional Services of Physicians nor intensive, private duty Nursing Services by whatever name called.

2.1.58 **Semi-Private:** Shall be defined as a class of accommodations in a Hospital or Skilled Nursing Facility in which at least two (2) patient beds are available per room.

2.1.59 **Services:** Shall be defined as medical, dental or other health care services, treatments, supplies, medications and equipment.

2.1.60 **Service Area:** Shall be defined as Guam and the Commonwealth of the Northern Mariana Islands. Enrollment to this Plan is limited to individuals residing in the Service Area.

2.1.61 **Skilled Nursing Facility:** Shall be defined as a specially qualified and licensed facility that:

2.1.61.1 For a fee and on an Inpatient basis, provides 24 hour per day skilled Nursing services under the full-time supervision of a Physician or Nurse and provides physical restoration services for persons convalescing from an Injury or Illness; and

2.1.61.2 maintains daily clinical records; and

2.1.61.3 complies with legal requirements applicable to the operation of a skilled nursing institution; and

2.1.61.4 has transfer arrangements with one or more Hospitals; and

2.1.61.5 has an effective utilization review plan; and

2.1.61.6 is approved and licensed by the jurisdiction in which it operates.

2.1.62 **Specialty Drugs:** Charges for medications used to treat certain complex and rare medical conditions. Specialty drugs are often self-injected or self-administered. Many grow out of biotech research and may require refrigeration or special handling.

2.1.63 **Subscriber:** Shall be defined as a Covered Person.

2.1.64 **Surgery and Surgical Services:** Shall be defined as Medically Necessary Services directly performed by a Physician in the treatment of an Injury or Illness which requires one or more of the following: cutting; suturing; diagnostic or therapeutic endoscopic procedures; debridement of wounds, including burns; surgical management or reduction of fractures or dislocation; orthopedic casting; manipulation of joints under general anesthesia; or destruction of localized lesions, cryotherapy or electrosurgery. The term "Surgery" does not include Dental Services, routine venipuncture or minor endoscopic examinations.

2.1.65 **Terminally Ill:** Shall be defined as a medical prognosis of limited expected survival of six (6) months or less at the time of referral to a Hospice of a Covered Person with a chronic, progressive Illness which has been designated by the Covered Person's attending Physician as incurable.

2.1.66 **Urgent Care:** Shall be defined as the delivery of ambulatory medical care outside of a hospital emergency department on a walk-in basis, without a scheduled appointment. Urgent care centers treat many problems that can be seen in a primary care physician's office, but urgent care centers offer some services that are generally not available in

primary care physician's offices such as x-rays and minor trauma treatment.

§2.2 PPACA Requirements: It is the intent of this Agreement to provide, at a minimum, all of the benefits, rights and responsibilities afforded as a result of the Patient Protection and Affordable Care Act (Public Law 111-148), and the regulations promulgated under the authority of this Act, except for the benefits, rights and responsibilities as specifically excluded by GovGuam.

§2.3 Guaranteed Renewability of Health Insurance Coverage: In the event that GovGuam invokes the protection afforded by the Health Insurance Portability and Accountability Act of 1996, as amended, found at Section 2712 of the Public Health Services Act, and its regulations, for the guaranteed renewability of health insurance coverage the parties agree that coverage would be continued until a new contract is in place with the first ninety (90) days of coverage guaranteed at the same rate and plan designs.

ARTICLE 3

Services

§3.1 Company shall provide Covered Persons with the GovGuam Retiree Supplement Plan, subject to the applicable limitations and conditions, set forth in this Agreement and the attached Exhibits incorporated herein.

§3.2 Company shall provide Covered Persons with Additional Insurance Benefits coverage in the Philippines, at Participating Providers, and when pre-authorized by the Company, for services not covered by Medicare, consistent with the extent of services and subject to the exclusions set out in the Group Health Certificate, incorporated herein, on a first dollar basis without deductible, and without co-payment.

§3.3 Company shall provide Covered Persons an Optional Dental Benefits Plan subject to the applicable limitations and conditions set forth in this Agreement and the Optional Dental Benefits Plan incorporated in the Group Health Certificate.

§3.4 Company shall pay the co-payments, deductibles, and co-insurance required by Medicare and treat Covered Person as having met the Out-of-Pocket maximum under the plan for purposes of receiving benefits under this Agreement.

ARTICLE 4

Rates and Premiums and Experience Participation

§4.1 Rates. Company shall provide the GovGuam Retiree Supplement Insurance benefits set forth in §3.1 and the Additional Insurance benefits set forth in §3.2 for the semi-monthly rate of \$181.00 for Class I and \$361.50 for Class II effective October 1, 2017 through September 30, 2018, and the optional Dental Plan set forth in §3.3 for the semi-monthly rate of \$17.00 for Class I and \$38.50 for Class II effective October 1, 2017 through September 30, 2018.

§4.2 Premium Payment. GovGuam shall pay the Premium due under this Agreement to Company within fifteen (15) business days after the close of each GovGuam pay period. Each such Premium payment shall be for the preceding pay period. Payment in full of all Premiums due constitutes a discharge of GovGuam's responsibility for the cost of benefits and administration provided under this Agreement. Should GovGuam fail to pay any Premium when due under this Agreement, Company shall have the right to suspend performance under this Agreement with respect to any Covered Person whose Premium payments have not been paid by GovGuam, in addition to the right of termination under Article 5.2.1 and Article 5.3. However, such suspension may only take place after Company provides written notice to GovGuam at least ten (10) days prior to the suspension stating the names of the Covered Persons at risk of suspension and the amount of Premium owed for each. Further, Company shall retroactively reinstate a Covered Person's right to benefits upon full payment of the past due Premiums only if the premiums are paid within 120 days after the notification of the suspension.

ARTICLE 5

Term and Termination

§5.1 Term. The Agreement is for a one year term beginning October 1, 2017 and ending September 30, 2018, unless terminated for major default in services, given by written notice from GovGuam to Company not less than ninety (90) calendar days or unless modified by mutual agreement.

§5.2 Termination.

5.2.1 By Company. If GovGuam fails to make any Premium payment within fifteen (15) days after receipt of a written notice of non-payment from Company, Company may terminate this Agreement by providing at least fifteen (15) days prior written notice of termination to GovGuam and all Subscribers under this Agreement.

§5.3 Individual termination.

5.3.1 Non-payment of Premium. Company may, in accordance with the notice provisions contained in §5.2.1, terminate the coverage of one or more individual Covered Persons for non-payment of Premium without terminating this Agreement as to other Covered Persons for whom Premiums have been received by Company.

5.3.2 Other Reasons. Except for non-payment of Premiums, Company may only terminate a Covered Person as provided in Article 5 of the Group Health Certificate attached hereto.

5.3.3 Review of Termination. Any Covered Person whose coverage is terminated pursuant to this Section 5.3 shall be entitled to a review through the PPACA Claims Procedure set forth in this Agreement, if so requested.

§5.4 Effect of Termination. In the event of termination of this Agreement for a Covered Person, Company shall be responsible for providing the benefits contained in this Agreement up to the effective date of termination and GovGuam shall be responsible for payment of the Premiums up to said effective date.

ARTICLE 6

Enrollment

§6.1 Regular Open Enrollment. The parties to this Agreement shall establish one (1) open Enrollment period, which shall be the same period as for all Other Plans offering health insurance and/or health benefits programs to GovGuam. During such period GovGuam shall provide Company with the assistance and cooperation detailed in Article 8. Except as provided in §6.1.1, §6.2 and §6.3 below, the open Enrollment period is the only time during which current and potential Covered Persons shall be allowed to enroll in this Plan or to disenroll from this Plan. The effective date of such Enrollment or disenrollment shall be the effective date of this Agreement, unless otherwise specified by GovGuam in accordance with this Agreement, or unless otherwise required under HIPAA or Social Security Act of 1882.

6.1.1 Special Open Enrollments. If GovGuam holds a special open Enrollment during the Plan Year, Company shall participate in such special open Enrollment, unless otherwise agreed by the parties, or unless the Plan is no longer to be offered as of the entry date of the special open Enrollment period. If the special open Enrollment shall impact on rates, the parties shall negotiate an appropriate change prior to the participation of Company in such special open Enrollment.

§6.2 Newly Eligible Persons. Subject to §6.3, any individual who first becomes eligible to be a Covered Person outside the open Enrollment period, shall have thirty (30) days after the date on which he/she became eligible to become a Covered Person. The effective date of such Enrollment shall be as specified in §5.5 of the Certificate.

§6.3 Otherwise Eligible. Enrollment shall be restricted to only those occasions provided for in this Article 6 unless an individual is eligible for Enrollment under the HIPAA provisions allowing special enrollment rights. Enrollment shall be in accordance with HIPAA and PPACA requirements.

ARTICLE 7

Company's Responsibilities

§7.1 Marketing. Company shall print and provide necessary brochures, announcements, instructions, Enrollment forms, and certificates for Enrollment purposes and for distribution to potential Covered Persons. Company shall be responsible for the dissemination of information to potential Covered Persons regarding the Plan. Company shall provide agreed upon quarterly communication to members clearly defining the benefits of the current plans in place. Company will work directly with the Government of Guam to determine their needs in distribution, and type of communication desired.

§7.2 Benefits to be Provided. Company shall, in consideration of receipt of applicable Premiums, provide the benefits contained in this Agreement through the earlier of the effective date of a Covered Person's termination or the termination of this Agreement.

§7.3 Financial and Medical Cost Information. In accordance with Title 4 GCA, Section 4302 (b) and (g), Company shall provide GovGuam detailed claims utilization and cost information, and shall provide upon reasonable request, the most recent audited financial statements, experience data, and any other information pertaining to this Agreement. GovGuam may, upon reasonable notice of no less than fifteen (15) working days, audit Company to confirm the accuracy of the information provided specifically to the government of Guam book of business.

§7.4 Confidential Information. The parties hereto shall maintain the confidentiality of any and all medical records which shall be in their possession and control, and such information shall only be released or disseminated pursuant to the valid authorization of the Covered Person whose medical condition is reflected in such medical records or as shall be otherwise permitted under applicable law. Upon request and subject to applicable law, Company shall make available to GovGuam medical records to assure Covered Persons are receiving adequate and appropriate benefits in accordance with the Certificate.

§7.5 Errors and Omission Insurance. The Company shall use all reasonable efforts to secure and maintain current errors and omission liability insurance of at least One Million Dollars (\$1,000,000) during the term of this Agreement.

§7.6 Payment of Claims. Company shall pay claims in accordance with the Guam Health Care Prompt Payment Act of 2000 and the applicable claims payment requirements of PPACA. Appeals of claim denials shall comply with applicable requirements of PPACA claim and external review requirements.

§7.7 Notification. Company shall fulfill the notice requirements of the Women's Health and Cancer Rights Act of 1998, and the Newborns' and Mothers' Health Protection Act of 1996, and shall be responsible for notice requirements applicable to PPACA requirements.

§7.8 Termination Notification. If the Company terminates this Agreement, Company shall provide notice announcing its termination at least fifteen (15) days prior to the date of termination on the Company's website, an ad in any of the local newspaper publications, and email to subscribers of the Company's Plan. Further, Company shall fully cooperate with GovGuam in transitioning Covered Persons to Other Plans.

§7.9 Sole Source Provider. If there is a Covered Service which is provided on Guam by only one provider who is not a Participating Provider, the eligible Charges for such services shall be as if the sole source provider were a participating provider.

§7.10 Performance Guarantees. Performance guarantees have the appropriate annual penalties listed by each guarantee as stated in Exhibit E with a maximum amount of \$105,000 annually. The penalties, if any, are to be paid annually upon an annual review meeting within thirty (30) days after the end of the plan year.

§7.11 Online Access Capabilities. The Company shall provide, for the benefit of the Covered Person and GovGuam, the following online access capabilities:

7.11.1 Online access is available twenty-four (24) hours a day, seven (7) days a week in accordance with Section 508 standards of the Rehabilitation Act of 1973 as amended.

7.11.2 For the Covered Person, access to Personal Health Record ("PHR") to include historical health conditions, prescription medications, office visit summary and procedures where a medical claim has been filed.

7.11.3 For the Covered Person, access to record of medical and drug claims.

7.11.4 For the Covered Person, ability to verify eligibility.

7.11.5 Ability of Providers to submit claims through a separate portal rather than through Company's website for payment.

7.11.6 For the Covered Person, GovGuam, and Providers access to Schedule of Benefits, Member Handbooks and Provider Network Information.

7.11.7 For the Covered Person, ability to print PHR to federal compliance standard file formats or plain text file.

7.11.8 For the Covered Person, ability to print online membership cards.

7.11.9 For the Covered Person, access to interactive tools for researching health issues, treatments, and risk assessment tools for health conditions.

ARTICLE 8

GovGuam's Responsibilities

§8.1 **Marketing.** GovGuam shall give Company reasonable assistance and cooperation to enable Company to contact all sources of Enrollment, to disseminate all information, to distribute and post literature, to provide access to employees during working hours, to provide all employees' names and addresses, and to instruct department heads to provide Company's representatives reasonable opportunity for personal contact with employees, consistent with that given other GovGuam contracted health plans, for the purpose of explaining Company's Plan to GovGuam employees.

§8.2 **Responsible Persons.** GovGuam shall designate persons within each agency, department and branch, who shall be responsible for the handling of health insurance problems, Enrollment, and cancellations within their particular department. These designated persons shall be available to attend meetings on government time for the purpose of reviewing administrative procedures, and to assist in problem solving relating to this Agreement.

§8.3 **Personnel Changes.** GovGuam shall provide written notice to Company of terminations, resignations, department transfers, and the like, so that coverage can be terminated at the appropriate time. GovGuam shall make available to Company a computer listing of each employee receiving an applicable payroll deduction for Premiums no later than fifteen (15) working days following each pay period.

8.3.1 **Individual with Questionable Status.** If GovGuam does not provide the list of employees as required in §8.3, Company shall have the right to charge an individual whose Enrollment is in question for any Covered Services rendered prior to receipt of written verification of eligibility and Enrollment by GovGuam. If such individual is subsequently determined to be a Covered Person, and GovGuam remits a Premium payment for the Covered Person for the period for which the Covered Services were rendered, Company shall cancel all charges to the Covered Person and return any amounts collected. If Company files a written objection to an Enrollment list forwarded by GovGuam, then within thirty (30) days after the filing, GovGuam shall provide Company with the applicable change of status forms, Enrollment cards, and other documentation substantiating the accuracy of the Enrollment records and meet with Company to reconcile any differences. Evaluation of such individual's entitlement shall be handled in accordance with PPACA's applicable Claims Procedure

requirements, taking into account any applicable PPACA prohibition on rescissions and any applicable PPACA requirement that costs of care be provided or continued during evaluation period

§8.4 **No restrictions on Enrollment.** GovGuam shall place no restriction or limitation on the percentage or number of Enrollments in the Plan.

ARTICLE 9

Covered Person's Responsibilities

§9.1 **Acceptance.** By Enrolling in the Plan, all Covered Persons agree to the terms, provisions and conditions of this Agreement.

§9.2 **Continued Residency.** Except as specifically stated in this Agreement, Enrollment in the Plan shall be limited to Covered Persons domiciled in the Service Area, and who do not reside outside the service area for more than one hundred eighty-two (182) days per plan year. Company shall be entitled to require substantiation from a Covered Person to determine the Covered Person's Domicile and may deny benefits under this Agreement for lack thereof. For a Covered Person Domiciled in the Service Area, time spent receiving continuous medical Services out of the Service Area shall not count toward the one hundred eighty-two (182) day maximum, provided the receipt of such Services precludes returning to the Service Area. Further, time spent by a parent or Spouse of such covered person shall not count toward the one hundred eighty-two (182) day maximum, provided the parent or Spouse is providing necessary assistance to the Covered Person and further provided that under no circumstance can there be more than one such caregiver hereunder for any incident of care out of the Service Area.

§9.3 **Continued Enrollment in Medicare.** Covered Person agrees to be continuously enrolled in Medicare Parts A (Hospital) & B (Medical) for the entire benefit year (Oct. 1, 2017 - Sept. 30, 2018).

ARTICLE 10

Notices

§10.1 **Address of Record.** For the purpose of communication and services of notice under this Agreement, the parties' addresses are as follows:

To: TokioMarine Pacific Insurance, Limited
c/o Calvo's SelectCare
115 Chalan Santo Papa
Hagatna, Guam 96910

To: GovGuam
Director
Department of Administration
Government of Guam
590 S. Marine Corps Dr., Ste. 224
Tamuning, Guam 96913

§10.2 **Method of Service.** Notices shall be in writing and effective upon either receipt of a hand-delivered notice or the posting of notice by first class mail, postage prepaid, to the address listed herein or such other address as a party may designate by providing written notice to the other party from time to time.

ARTICLE 11

Dispute Resolution

§11.1 **Mandatory Disputes Resolution Clause (As amended but consistent with 2 GAR Div. 4 § 9103(g) and applicable law).** GovGuam and the Company agree to attempt resolution of all controversies which arise under, or are by virtue of, this Agreement through mutual agreement. If the controversy is not resolved by mutual agreement, then the Company shall request GovGuam in writing to issue a final decision within sixty days after receipt of the written request. If GovGuam does not issue a written decision within sixty days after written request for a final decision, or within such longer

period as may be agreed upon by the parties, then the Company may proceed as though GovGuam had issued a decision adverse to the Company. GovGuam shall immediately furnish a copy of the decision to the Company, by certified mail with a return receipt requested, or by any other method that provides evidence of receipt. GovGuam's decision shall be final and conclusive, unless fraudulent or unless the Company appeals the decision. This subsection applies to appeals of GovGuam's decision on a dispute. For money owed by or to GovGuam under this Agreement, the Company shall appeal the decision in accordance with the Government Claims Act by initially filing a claim with the Office of the Attorney General no later than eighteen months after the decision is rendered by GovGuam or from the date when a decision should have been rendered. For all other claims by or against GovGuam arising under this Agreement, the Office of the Public Auditor has jurisdiction over the appeal from the decision of GovGuam. Appeals to the Office of the Public Auditor must be made within sixty days of GovGuam's decision or from the date the decision should have been made. The Company shall exhaust all administrative remedies before filing an action in the Superior Court of Guam in accordance with applicable laws. The Company shall comply with GovGuam's decision and proceed diligently with performance of this Agreement pending final resolution by the Superior Court of Guam of any controversy arising under, or by virtue of, this Agreement, except where the Company claims a material breach of this Agreement by GovGuam. However, if GovGuam determines in writing that continuation of services under this Agreement is essential to the public's health or safety, then the Company shall proceed diligently with performance of the Agreement notwithstanding any claim of material breach by GovGuam.

ARTICLE 12

Governing Law

The rights and responsibilities of the parties and their respective officers, directors, employees, agents and representatives under this Agreement and their performance hereunder shall be governed by the laws of Guam.

ARTICLE 13

Miscellaneous

§13.1 Government Laws and Regulation. Company guarantees the negotiated rates shall remain in effect for the Plan Year. However, if during such year the Government of the United States or GovGuam enacts statutes or promulgates regulations which (i) require that the Company offer different coverage to Covered Persons than that specifically provided in this Agreement; or (ii) causes an increase or decrease in Provider rates or other costs, the parties reserve the right on thirty (30) days written notice to the other to adjust the Premiums if the parties mutually determine that such mandate or law shall change Company's costs under this Agreement by more than five percent (5%). Where the Agreement indicates that a PPACA requirement might override a specific limitation, this section 13.1 shall apply if it is determined that a PPACA override is in fact required.

§13.2 Contingent Fee Warranty. Company warrants that it has not retained anyone to solicit or secure this Agreement for payment of a commission, percentage, brokerage, or contingent fee, except for Company's bona fide employees or any bona fide established commercial selling agencies which Company may disclose to GovGuam.

§13.3 Gratuity Warranty. Company warrants that it has not violated, is not violating, and promises it shall not violate the prohibition against gratuities and kickbacks set forth in Guam Procurement Regulations at Title 2, GAR, Div. 4 §11107.

§13.4 Personal Interest Disclaimer. Company warrants that no member of any governing body of any agency of GovGuam and no officer, employee, or agent of GovGuam who exercises any functions or responsibilities in connection with the work to which this Agreement pertains has or shall have any personal interest, direct or indirect, in this Agreement, except that such members, officers or employees may be Covered Persons under the Plan. Company further warrants that no member of the Guam Legislature and no other official of GovGuam who exercises functions and responsibilities in connection with the work to which this Agreement pertains has or shall have any personal interest, direct or indirect, in this Agreement except as possible Covered Persons under the Plan.

§13.5 Captions. The captions, section numbers and article numbers and marginal notes appearing in this Agreement or in any copies of this Agreement are placed there only as a matter of convenience and in no way define, limit, or describe the scope or intent of this Agreement.

§13.6 Waiver. The waiver of any breach of this Agreement by either party shall not be deemed a waiver of any other breach or a waiver of any subsequent breach of the same nature.

§13.7 Excused Non-Performance. The parties' performance hereunder shall be excused when the failure of performance is caused by fire, explosion, acts of God, civil disorder, war, riot or other event not reasonably within the control of the party.

§13.8 Entire Agreement. This Agreement, including the Certificate and Exhibits A through F, is the entire Agreement between the parties. There are no terms or obligations other than those contained herein applicable to this Agreement. This instrument shall supersede all previous communications or representations, whether verbal or written between the parties.

§13.9 Amendment. This Agreement may only be amended upon the written consent of both parties.

§13.10 Time of Essence. Time is expressly made of the essence in this Agreement and for performance hereunder.

§13.11 Limitation of Actions. Any action in relation to this Agreement must be brought no later than one (1) year from the time such claim arises or should have been reasonably discovered.

§13.12 Third Party Rights. Nothing in this Agreement, whether expressed or implied, is intended to confer any rights or remedies under or by reason of this Agreement on any persons other than the parties to this Agreement and their respective successors and assigns.

§13.13 Successors in Interest. Each and all of the covenants, conditions, and restrictions in this Agreement shall inure to the benefit of and shall be binding upon the assignees and successors in interest of Company. However, Company shall not be entitled to assign its interest in this Agreement, or any prior or future agreement with GovGuam, without the express written consent of GovGuam.

§13.14 Severability. If any term or provision of this Agreement or the application thereof shall to any extent be determined to be invalid or unenforceable, the remainder of this Agreement or the application of such remainder, other than as held invalid or unenforceable, shall not be affected and each term and condition of this Agreement shall be valid and be enforceable to the fullest extent permitted by law.

§13.15 Counterparts. This Agreement, including the Group Health Certificate and Exhibits may be executed by the parties in several counterparts, each of which shall be deemed to be an original copy.

§13.16 Legal Compliance. Company shall comply with applicable federal and local statutes and regulations, including the certification requirements of HIPAA and applicable requirements of PPACA and the PHSA. To the extent not preempted by the laws of the United States, this Agreement will be construed in accordance with and governed by the laws of Guam. In the event of conflict between any provision of this Agreement and applicable law, the law shall govern.

§13.17 Determination of Currency Exchange Payments. When a service is rendered outside of the United States, the claims shall be paid in accordance with Company's agreements with its participating providers. Claims for nonparticipating providers will be reimbursed using the Philippines fees as a reference. Additionally, claims incurred outside of the United States will be based on the date of service and will be converted according to the conversion rate, for cash transactions, against the U.S. Dollar as found in XE.com and for credit card transactions, against the utilized specific conversion rate for the card used. For multiple dates of service, the rate will be calculated based on the last date of service or payment, whichever is earlier in time.

§13.18 Restriction Against Contractor Employing Sex Offenders to Work at Government of Guam Venues.

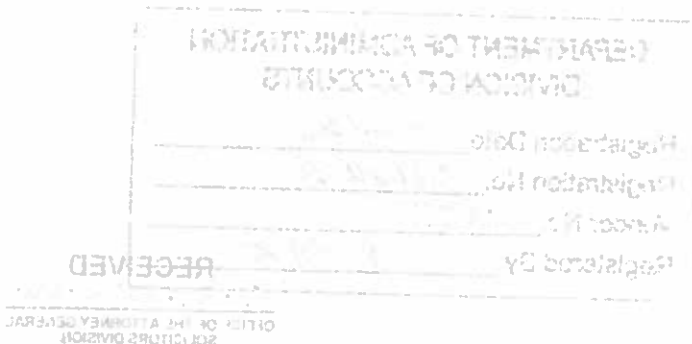
The Company warrants that no person convicted of a sex offense under the provisions of Chapter 25 of Title 9 Guam Code Annotated, or an offense as defined in Article 2 of Chapter 28, Title 9 Guam Code Annotated, in Guam, or an offense in any jurisdiction which includes, at a minimum, all of the elements of said offenses, or who is listed on the Sex Offender Registry, shall work for the Company on property of the government of Guam other than a public highway. Further, the Company warrants that if any person providing services on behalf of the Company is convicted of a sex offense under the provisions of Chapter 25 of Title 9 Guam Code Annotated or an offense as defined in Article 2 of Chapter 28, Title 9 Guam Code Annotated or an offense in another jurisdiction with, at a minimum, the same elements as such offenses, or who is listed on the Sex Offender Registry, that such person will be immediately removed from working at such agency and that the administrator of said agency be informed of such within twenty-four (24) hours of such conviction.

§13.19 Ethical Standards. With respect to this Agreement and any other contract the Company may have, or wish to enter into, with any government of Guam agency, Company represents that it has not knowingly influenced, and promises that it will not knowingly influence, any government employee to breach any of the ethical standards set forth in the Guam Procurement Law and in any of the Guam Procurement Regulations.

§13.20 Minimum Wages As Determined by U.S. Government. Company agrees to comply with Title 5, Guam Code Annotated, Sections 5801 and 5802. In the event that Company employs persons whose purpose, in whole or in part, is the direct delivery of service contracted by the Government, then the Company shall pay such employees, at a minimum, in accordance with the U.S. Department of Labor Wage Determination for Guam and the Commonwealth of the Northern Marianas Islands in effect on the date of this Agreement. In the event that this Agreement is renewed by the Government and the Contractor, at the time of the renewal, Company shall pay such employees in accordance with the Wage Determination for Guam and the Commonwealth of the Northern Marianas Islands promulgated on a date most recent to the renewal date. Company agrees to provide employees whose purpose, in whole or in part, is the direct delivery of service contracted by the Government those mandated health and similar benefits having a minimal value as detailed in the U.S. Department of Labor Wage Determination for Guam and the Commonwealth of the Northern Marianas Islands, and guarantee such employees a minimum of ten (10) paid holidays per annum per employee.

****THE REMAINING SPACE LEFT INTENTIONALLY BLANK****

****SIGNATURE PAGE FOLLOWS****



18-0366

IN WITNESS WHEREOF, GovGuam and Company have signed this Agreement on the aforementioned date.

Government of Guam

By: [Signature]
Tokio Marine Pacific Insurance, Ltd.

Date: 03/14/2018

By: [Signature]
Acting Director, Department of Administration
Date: 5-7-18

By: [Signature]
Acting Insurance Commissioner,
Department of Revenue & Taxation
Date: 6/6/18

Effective Date:

October 1, 2017

By: [Signature]
Director, Bureau of Budget and
Management Research
Date: JUN 15 2018

CLEARED PER
BBMR'S REVIEW

Approved as to Legality and Form:

By: [Signature]
Attorney General
Date: 8/15/18

By: [Signature]
The Honorable Raymond S. Tenorio
Lieutenant Governor of Guam
Date: 5/21/2018

RECEIVED

JUN 11 2018

Bureau of Budget and
Management Research

DEPARTMENT OF ADMINISTRATION
DIVISION OF ACCOUNTS

Registration Date 05/21/2018
Registration No. C18064022
Vendor No. 50097689
Registered By: [Signature]

RECEIVED

OFFICE OF THE ATTORNEY GENERAL
SOLICITORS DIVISION

07-05-18

**GOVERNMENT OF GUAM
and
TOKIO MARINE PACIFIC INSURANCE, LIMITED
GROUP HEALTH CERTIFICATE
GOVGUAM RETIREE SUPPLEMENT INSURANCE**

This Certificate, including Exhibits, describes the retiree supplement group health insurance benefits that shall be provided to each Covered Person, the circumstances under which the benefits shall be provided, limitations on and exclusions from benefits, and provisions for termination of benefits. No benefits are available under the Plan, except as set forth herein. In the event of a conflict between the provisions of this Certificate and those of the Exhibits, the provisions of this Certificate shall govern.

This Additional Insurance Benefits plan provides coverage to covered Persons in the Philippines, Korea, Japan, or other Pacific-Asian locations at Participating Providers, and when pre-authorized by the Company, for services not covered by Medicare, consistent with the extent of services and subject to the exclusions set out herein on a first dollar basis without deductible, and without co-payment.

ARTICLE 2

Medical Benefits

Medical Benefits. Subject to the terms and conditions of this Agreement, payment for the Covered Services contained in this Article 2 ("Medical Benefits") shall be paid by Company when provided in accordance with this Agreement.

§2.1 **Physician Services.** Visits to or by a Physician for a non-Surgical health Services as a Covered Person may require in the treatment of an Injury or Illness.

2.1.1 **Primary Care Services.** As required by Section 2719A of the PHSA, as added by PPACA, each Covered Person shall be entitled to designate any Participating Provider who is a Primary Care Physician and who is available to accept the Covered Person as the Primary Care Physician for that Covered Person.

- Office visits with your Primary Care Physician during office hours
- Treatment for illness and injury
- Routine physical examinations
- Annual prostate screening (PSA) and digital exam for males age 40 and over, and for males considered to be at high risk who are under age 40
- Routine gynecological examinations and Pap smears for females, performed by your Primary Care Physician or a participating gynecologist. No referral to a gynecologist is required for a female to obtain covered gynecological care from a gynecologist.
- Annual mammography screening for asymptomatic women age 40 and older

Note: Diagnostic mammography for women with signs or symptoms of breast disease is covered as medically necessary.

- Routine immunizations (except those required for travel work)
- Annual eye examinations without a referral to a participating provider
- Routine hearing screenings

2.1.2 **Specialist Care Services.** Services provided by a medical specialist to whom a patient has been referred, usually by a primary care provider.

- Participating specialist office visits.
- Participating specialist consultations, including second opinions.
- Outpatient surgery for a covered surgical procedure when furnished by a participating outpatient surgery center. All outpatient surgery must be approved in advance by the Company.
- Preoperative and postoperative care.
- Casts and dressings.
- Radiation therapy.
- Cancer chemotherapy.
- Short-term cardiac rehabilitation provided on an outpatient basis following angioplasty, cardiovascular surgery, congestive heart failure or myocardial infarction.
- Short-term pulmonary rehabilitation provided on an outpatient basis for the treatment of reversible pulmonary disease.
- Hearing Aids - Coverage will be provided for medically necessary expenses incurred in the purchase of a hearing aid for Covered Persons. Hearing aid replacement when it is medically necessary and prescribed by a licensed physician or audiologist. Coverage is limited to \$500 per covered person per plan year. Replacement once every twenty four months.

2.1.3 Home or office visit. Each home or office visit, including charges for injections, inclusive of materials.

2.1.4 Hospital or Skilled Nursing Facility visit. Visit to a Covered Person who is a Registered Bed Patient at a Hospital or Skilled Nursing Facility.

2.1.5 Intensive Care Unit visit. A visit for a critical Injury or Illness provided that the Covered Person is a Registered Bed Patient.

§2.2 **Preventive Physical Exam.** A routine preventive physical examination (including limited hearing testing and mammograms in accordance with the U.S. Preventive Services Task Force Recommendations with a Grade A or B only). Physical examinations required for obtaining or continuing any employment, insurance, schooling or licensing are excluded from this benefit. Coverage for routine preventive physical exam is limited to one exam per plan year

2.2.1 PPACA Preventive Care Services (with no Deductibles, Co-Payments or Co-Insurance) when provided by Participating Providers.

2.2.2 Routine preventive physical examination coverage at a Participating Provider in the Philippines with no maximum.

§2.3 **Preventive Lab Services.** Preventive Lab Services is covered at One Hundred percent (100%) with no co-payments, co-insurance, or deductibles in accordance with PPACA.

§2.4 **Immunizations.** Charges incurred in connection with immunizations in accordance with the guidelines provided by the United States Preventive Services Task Force. See Exhibit D, 'Schedule of Covered Immunizations.'

• **§2.5 Injections.** Other than immunizations, an infusion method of putting fluid into the body, usually with a hollow needle and a syringe which is pierced through the skin to a sufficient depth for the material to be forced into the body. There are several methods of injection or infusion, including intradermal, subcutaneous, intramuscular, intravenous, intraosseous, and intraperitoneal.

§2.6 Allergy testing A maximum benefit of One Thousand Dollars (1000) per Plan Year per Covered Person for charges for allergy testing.

§2.7 Basic Hospital benefits. The Hospital benefits to which a Covered Person is entitled while medically necessary and reasonably confined as a Registered Bed Patient are limited to a maximum of three hundred and sixty-five (365) days of confinement during a Plan Year, in accordance with evidence based medical guidelines. If necessarily incurred during said period, the following Services shall be Covered Services:

2.7.1 Hospital Room and Board. Coverage is provided at the Hospital's most common Semi-Private room rate, or at the Hospital's daily average private or single room rate if there are no Semi-Private accommodations or if a private room is Medically Necessary.

2.7.2 Intensive Care Unit. Room and Board charges for a stay in an intensive care unit which is equipped and operated according to generally recognized Hospital standards.

2.7.3 Cardiac room. Charges for a stay in a cardiac room which is equipped and operated according to generally recognized Hospital standards.

2.7.4 Surgery. Charges for the operating room, surgical supplies, Hospital Anesthesia Services, drugs, dressings, oxygen and antibiotics.

2.7.5 Diagnostics. Charges for diagnostics to the extent the same are not provided under Article 2.9.

2.7.6 Outpatient Hospital benefits. Hospital charges incurred by a Covered Person for use of a Hospital's outpatient facilities in connection with an Injury or Illness as follows:

2.7.6.1 Emergency medical Services within twenty-four (24) hours of a serious Injury or the sudden onset of an acute Illness, or such longer time as may be necessary to stabilize a covered individual in accordance with the emergency definitions and requirements of PPACA in the case of PPACA Emergencies.

2.7.6.2 Medical Services received on the day of and in connection with Surgery.

2.7.6.3 Pre-admission tests and/or examinations.

2.7.6.4 Medical Services which cannot be rendered in a Physician's office.

2.7.6.5 Non-Emergency. Company shall not pay for charges incurred for use of a Hospital's outpatient facilities, supplies and equipment in connection with elective minor Surgical Services, non-Emergency Services or health Services that could be received in a Physician's office. Services in the emergency setting must meet the definition of Emergency. The Company reserves the right to audit and review the claim retrospectively to validate the nature of the condition for which services were provided. The Company shall not pay for non-Emergency use of the Hospital's emergency facilities, unless the condition is urgent and treatment is unavailable elsewhere at the time.

2.7.7 Ambulatory Surgical Center benefits. Charges for Outpatient Surgery.

§2.8 Basic Surgical benefits. The Surgical benefits to which a Covered Person is entitled are as follows:

2.8.1 Surgical Services. Charges for Surgical Services the Covered Person may require in the treatment of an Injury or Illness, including charges for such Medically Necessary after visits in connection with the particular Surgical Services performed. Any charges for non-Medically Necessary after Service visits shall not be paid.

2.8.2 Anesthesiology. Charges of a private anesthesiologist or Hospital anesthesiologist when the Services of an anesthesiologist are Medically Necessary.

2.8.3 Gastric Banding and Bariatric Surgery. Gastric banding and bariatric surgery will only be covered if such treatment is in accordance with the following:

- Company covers bariatric surgery using a covered procedure outlined below as medically necessary when ALL of the following criteria are met:
 - The individual has reached full expected skeletal growth AND has evidence of EITHER of the following:
 - a BMI (Body Mass Index) ≥ 40
 - a BMI (Body Mass Index) 35-39.9 with at least one clinically significant comorbidity, including but not limited to, cardiovascular disease, Type 2 diabetes, hypertension, coronary artery disease, or pulmonary hypertension
 - Failure of medical management including evidence of active participation within the last two years in a weight-management program that is supervised either by a physician or a registered dietician for a minimum of six months without significant gaps. The weight-management program must include monthly documentation of ALL of the following components:
 - weight
 - current dietary program
 - physical activity (e.g., exercise program)

Programs such as Weight Watchers®, Jenny Craig® and Optifast® are acceptable alternatives if done in conjunction with the supervision of a physician or registered dietician and detailed documentation of participation is available for review. For individuals with long-standing, morbid obesity, participation in a program within the last five years is sufficient if reasonable attendance in the weight-management program over an extended period of time of at least six months can be demonstrated. However, physician-supervised programs consisting exclusively of pharmacological management are not sufficient to meet this requirement.

- A thorough multidisciplinary evaluation within the previous 12 months which includes the following:
 - an evaluation by a bariatric surgeon recommending surgical treatment, including a description of the proposed procedure(s) and all of the associated current CPT codes
 - a separate medical evaluation from a physician other than the surgeon recommending surgery, that includes a medical clearance for bariatric surgery
 - unequivocal clearance for bariatric surgery by a mental health provider
 - a nutritional evaluation by a physician or registered dietician

2.8.4 Elective Surgery. Covered by plan in accordance with the Schedule of Benefits and must be pre-certified and approved by plan.

2.8.5 Robotic Surgery/Robotics Suite. Covered in accordance with basic surgical procedure benefits as indicated on the Schedule of Benefits. Robotic surgery/Robotics Suite must be pre-certified and approved by the plan.

2.8.6 Organ Transplant. Covered in accordance with basic surgical procedure benefits as indicated on the Schedule of Benefits. Transplant must be pre-certified and approved by the plan. Only the services, care and treatment received for, or in connection with, the pre-approved transplant of organs, which are determined by the Plan to be medically necessary services and which are not experimental, investigational or for research purposes

except as permitted through approved clinical trials will be covered by this Plan. Coverage for the organ donor is included.

§2.9 Basic diagnostic and therapy benefits.

2.9.1 Provider Services. Charges for the following Services when ordered by a Physician for the treatment of an Injury or Illness.

2.9.1.1 Laboratory Services. Charges for laboratory Services.

2.9.1.2 X-ray Services. Charges for diagnostic X-ray procedures.

2.9.1.3 Electrocardiograms. Charges for EKG procedures.

2.9.1.4 Radiotherapy. Charges for radiotherapy.

2.9.1.5 Inhalation Therapy. Charges for Inhalation Therapy provided as an Outpatient Service.

2.9.1.6 Sleep Apnea Studies/Polysomnograph. Charges for sleep apnea studies/polysomnograph - diagnostic and therapeutic procedures.

§2.10 Medical-related Dental Benefits. The following dental benefits are Covered Services:

2.10.1 Services rendered by a Dentist or Physician, and Hospital or Ambulatory surgi-center services related thereto, when required to treat traumatic injury to sound, natural teeth or jaw. Coverage is limited to palliative care to alleviate pain and other acute symptoms resulting from the Injury. Such may include debridement of wounds, suturing, extraction of broken teeth, splinting of loose teeth, wiring of jaws, smoothing jagged edges of broken teeth. Services must be completed within 12 months following the injury. Fillings, crowns, bridges, dentures, bonding and similar permanent restorations are excluded.

2.10.2 If a Participating Physician certifies, in advance, that a non-dental, medical condition makes admission necessary to safeguard the Covered Person in connection with Dental Services rendered by a Dentist, Hospital and Ambulatory Surgi-center Services rendered in connection therewith are covered.

§2.11 Home Health Care. Home Health Care, provided by allied health care professionals, is covered according to the schedule of benefits.

§2.12 Basic Skilled Nursing Facility benefits. The following Skilled Nursing Facility benefits are provided:

2.12.1 Skilled Nursing Facility benefits. If a Covered Person is confined as a Registered Bed Patient in a Skilled Nursing Facility, the Covered Person shall be eligible for benefits as if confined in a Hospital, except that the eligible period of confinement shall be limited to a maximum of sixty (60) days per Plan Year and payment for such benefits shall be the rates applicable for such Skilled Nursing Facility. To be eligible for these benefits, each of the following requirements must be met:

2.12.2 The admission to the Skilled Nursing Facility must be approved in advance by Company.

2.12.3 The Covered Person must be admitted on the authorization of a Physician and must continue to be attended by a Physician while confined.

2.12.4 Confinement in the Skilled Nursing Facility must not be primarily for comfort, convenience, rest cure or domiciliary care.

2.12.5 If a Covered Person remains in a Skilled Nursing Facility more than thirty (30) days, the attending Physician must submit to Company an evaluation report reviewing the thirty (30) day period of confinement and addressing the specific need for continued confinement.

§2.13 Hospice Care. Charges for a maximum of one hundred eighty (180) days per lifetime. The attending Physician must determine limited life expectancy of six (6) months or less. The Covered Person shall not be entitled to benefits for any Services for the Terminal Illness except for palliative care. Services must be provided through a bona fide Hospice. Coverage for Hospice Services shall be limited to One Hundred Fifty Dollars (\$150) per day.

2.13.1 Palliation Therapy is covered under the Hospice Care Benefit.

2.13.1.1 Palliation Therapy: Shall be defined as patient and family centered care that optimizes the quality of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social and spiritual needs and facilitating patient autonomy, access to information and choice. Palliative care should be covered on an outpatient basis only.

2.13.2 At least one of the treating Physicians must determine limited life expectancy of six months or less and certifies terminal illness of a Covered Person.

2.13.3 There must have been agreement by the Covered Person or the Covered Person's authorized representative to begin Hospice care as palliative and/or support only; and

The Hospice level of benefits begins on the date the above conditions are met. The Covered Person shall not be entitled to any care for the terminal illness except for palliative care. Medically necessary care for unrelated conditions shall continue as covered benefits, subject to plan benefits, deductibles, exclusions and limitations, medical necessity determinations and eligibility. Benefits for conditions normally covered, and not directly or indirectly related to the terminal condition are covered for inpatient, outpatient and emergency care in accordance with the schedule of benefits.

§2.14 Prescription Drugs

2.14.1 Charges for Prescription Drugs, including insulin and syringes, when prescribed by a Physician. Charges for Medically Necessary prescription drugs not contained on the Company's Preferred Drug Formulary shall be covered provided the Physician certifies to the Company that the non-formulary drug is Medically Necessary for the Covered Person, and that no formulary drug was appropriate.

2.14.2 Prescription Drugs shall be limited to a thirty (30) day supply except for birth control pills and mail order Prescription Drugs which may be issued in a ninety (90) day prescription.

2.14.3 Prescriptions may be refilled for a period up to six (6) months from the original date of prescription, if so specified by a Physician in writing on the prescription.

2.14.4 Prescription Unit represents the maximum amount of outpatient prescription medication that can be obtained at one time for a single co-payment. For most oral medications, a prescription unit is up to a 30-day supply of medication.

2.14.5 For other medications, a Unit represents a single container, inhaler unit, package or course of therapy. For habit-forming medication, a unit may be set at a smaller quantity for the covered person's protection and safety.

2.14.6 Participating Mail Order Pharmacy. A pharmacy which has contracted with Company's Pharmacy Benefits Manager to provide covered outpatient prescription drugs or medicines and insulin to Members by mail or other carrier.

2.14.7 **Participating Retail Pharmacy.** A community pharmacy which has contracted with Company's Pharmacy Benefits Manager to provide covered outpatient prescription drugs to Members.

2.14.8 **Benefits for outpatient prescription Drug Products dispensed by a mail service Network Pharmacy.** The following supply limits apply:

- As written by the provider, up to a consecutive 90-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits.

2.14.9 **Prescribed drugs in countries outside of the United States (U.S.)** may differ from those that require a prescription in the U.S. Drugs purchased outside the U.S. must be an equivalent product of one approved by U.S. federal law or there must be clinical evidence that prescribing the drug is consistent with the standard of medical practice in the Country where the prescription is issued.

§2.15 Specialty Drugs: Charges for medications used to treat certain complex and rare medical conditions. Specialty drugs are often self-injected or self-administered. Many grow out of biotech research and may require refrigeration or special handling.

§2.16 Health education. Charges for health education classes and materials in accordance with Exhibit C herein provided.

§2.17 Durable Medical Equipment. The rental cost of: standard hospital bed, cane single tip, cane quad tip, crutches (forearm, aluminum OR forearm, wood), walker (folding, adjustable with wheels OR folding, adjustable without wheels), oxygen refill, oxygen concentrator, oxygen portable with regulator, suction pump with supplies, suction tubing (replaceable every 3 months), yankauer oral suction catheter, tracheostomy care kits (for new and established tracheostomies), continuous positive airway pressure (CPAP) machine, and standard wheelchairs (to include extra-wide sizes), when prescribed by a Physician and then only at the prescribed level. If the total rental cost exceeds the purchase price, Company may, at its discretion, either rent or purchase the item for the Covered Person. This benefit is limited to one rental or purchase every three (3) years and is limited to standard equipment only, unless subject to a treatment plan.

§2.14 Mental health benefits. The charges for the diagnosis and treatment of mental illness, as that term is defined in Title 22, Guam Code Annotated, Section 28103, subject to the same conditions and restrictions applicable to physical illness.

§2.15 Ambulance Services. If a Covered Person is transported to a Hospital by ground ambulance from the place where an Injury occurred, or when prescribed by a Physician, eighty percent (80%) of the charges for such ground ambulance Services are payable if: (i) the Services are provided by a licensed ambulance service; and (ii) the transportation is to a Hospital capable of treating the Covered Person and which Hospital is nearest to the place of Injury or place of entering the ambulance.

§2.16 Tubal ligation. The charges for tubal ligations.

§2.17 Vasectomy. The charges for vasectomies on an outpatient basis only.

§2.18 Breast reconstruction. Reconstruction of the breast on which a mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and physical complications of all states of mastectomy, including lymphedemas, are covered. Such re-constructive procedures are not limited to re-constructive procedures necessitated by mastectomies performed while covered under this Plan.

§2.19 Blood products. Charges for blood and blood products and their administration.

§2.20 Preventive Care. To the extent required by PPACA, preventive care (with no cost-sharing) when preventive care is provided by Participating Providers.

§2.21 Preferred Provider(s) The following sections refer to charges incurred by a Covered Person for Covered Services provided by Preferred Providers:

2.21.1 The Covered Person has obtained written Prior Authorization from Company or Company's agent to receive Services from a Preferred Provider and has agreed to receive Services from such Preferred Provider chosen by Company or Company's agent. No Prior Authorization shall be required for Emergency or PPACA Emergency cases and the Covered Person may select the Preferred Provider where Emergency or PPACA Emergency Services shall be rendered.

2.21.2 Company is the primary payor based on the coordination of benefits provisions of this Certificate, unless the primary payor is Medicare for those Centers of Excellence located in the United States; provided, however, the Company shall be the primary payor for Preferred Providers outside of the United States and located in the Philippines, Korea, Japan, or other Pacific-Asian locations.

2.21.3 For Inpatient Services which are unavailable in Guam and rendered by the Preferred Providers.

2.21.3.1 Company shall pay 100% of these services.

2.21.3.2 Company shall waive any co-insurance for such Services.

2.21.3.3 Company shall only provide airfare for the Covered Person for the most direct route to and from the location of the Covered Person and the Preferred Providers as determined by Company.

Regardless of the location of the Covered Person, or if it is Medically Necessary to provide for a break in the trip, Company shall provide the lesser of the lowest applicable economy airfare or the lowest economy, round-trip airfare on a commercial direct flight between Guam and the Preferred Providers. In no event shall Company provide an air ambulance.

2.21.3.4 If the Service is one of the following specific procedures or conditions: open heart surgery, oncology surgery to include but not limited to the following cancers brain, lung, liver, kidney, adrenal, nasopharyngeal, tongue, prostate, colon, genito-urinary, breast and gynecological oncology, aneurysmectomy, pneumonectomy, intra cranial surgery, acute leukemia, gamma knife, or if the expected cost to the Company for off-island Covered Services exceeds \$25,000.00, Company shall pay the air fare of one companion of the Covered Person to the Center of Excellence [Preferred Providers] under the terms set forth in §2.21.3.3.

2.21.3.5 If it is Medically Necessary that a licensed medical attendant be with the Covered Person, Company shall provide for one airline seat for such attendant under the same terms set forth in §2.21.3.3.

2.21.3.6 If the Covered Person is unable to self-care, Company shall provide for one airline seat for a qualified assistant under the same terms as §2.21.3.3

2.21.3.7 Company may, at its option, make the travel arrangements for the Covered Person and his or her companion, attendant or assistant (if any) and purchase the airline tickets.

2.21.3.8 Company shall facilitate the Hospital/Physician arrangements for the Covered Person.

2.21.3.9 For Company to be liable to pay any airfare, the proposed Service to be performed at the Preferred Provider must be a specific procedure and not merely a diagnostic

work-up or to confirm or rule out the diagnosis of another Physician. In the event the covered person/attendant purchases the seat(s), the Company will reimburse for actual expenses incurred in purchasing Medically Necessary seat(s), but not more than the Company would have paid had it purchased the seat(s) for the companion in advance. In no event will company reimburse for any seat(s) purchased with frequent flyer miles.

2.21.4 For Ambulatory Surgical Center Services which are unavailable in Guam and rendered by Preferred Providers:

2.21.4.1 Company shall waive the twenty percent (20%) Co-Insurance.

2.21.4.2 Company shall facilitate the Surgicenter/Physician arrangements for the Covered Person.

2.21.5 Inpatient and Ambulatory Surgical Center Services which are unavailable in Guam and rendered by Preferred Providers:

2.21.5.1 Company shall waive the twenty percent (20%) Co-Insurance.

2.21.5.2 Company shall facilitate the Surgicenter/Physician arrangements for the Covered Person.

2.21.6 Only those facilities identified as Preferred Providers in the Company's most recently updated Provider Directory will qualify for the airfare benefit.

§2.22 If no Participating Provider available. If there is no Participating Provider available, within the United States, to provide necessary Covered Services to a Covered Person, Company will cover those services at a Non-Participating Provider, within the United States, unless otherwise agreed by the Covered Person, such that the Covered Person will have no greater out-of-pocket cost than he or she would have had had the Services been rendered by a Participating Provider.

§2.23 If not able to travel. In case Emergency medical care is needed off-island, and it is medically imprudent for the Covered Person to be transported to a Participating Provider, Company will cover Services rendered to the Covered Person at a Non- Participating Provider such that the Covered Person will have no greater out-of-pocket cost than he or she would have had had the Services been rendered by a Participating Provider.

ARTICLE 3

Specific Limitations on Benefits

§3.1 **Dollar limitations.** The medical benefits available under this Agreement are subject to the following specific dollar limitations per Covered Person, in addition to all other exclusions and limitations set forth in the Agreement and this Certificate:

3.1.1 **Maximum Annual Benefit.** The total benefits payable to or on behalf of a Covered Person shall be unlimited per Plan Year.

3.1.2 **Cardiac surgery.** Benefits for cardiac surgery, including, but not limited to catheterization, angioplasty, valve replacement/repair, bypass and pacemaker are included.

3.1.3 **Nuclear medicine.** Coverage for nuclear medicine and all Covered Services related thereto are included.

3.1.4 **Orthopedic conditions.** Coverage for orthopedic conditions and related internal and external prosthetic devices, are included.

3.1.4.1 Except as specifically limited under this Agreement, Services, supplies and devices related to the treatment of chronic or acute orthopedic conditions are covered. This includes, but is not limited to:

3.1.4.1.1 Prosthetic devices. Devices, including artificial joints, limbs and spinal segments.

3.1.4.1.2 Orthotic devices. Orthotic devices, which are defined as appliances or apparatus that support or align movable parts of the body, correct deformities or improve the functioning of movable parts of the body.

3.1.5 **Radiation therapy.** Coverage for radiation therapy and all Services related thereto shall be included.

3.1.6 **Allergy testing.** A maximum benefit of One Thousand Dollars (1000) per Plan Year for charges for allergy testing that are not considered essential benefits under PPACA. Benefits for Allergy testing and treatment that constitute essential benefits under PPACA are subject only to the PPACA Annual Limit.

3.1.7 **Annual refraction eye examination.** Coverage for annual eye examination is once per member per Plan Year and up to \$150 per member per Plan Year for "hardware" (frames, lenses, contacts, etc.).

3.1.8 **Blood and blood products and derivatives.** Coverage for blood and blood products/derivatives and services related thereto shall be included.

3.1.9 **Hearing aids.** Coverage for hearing aids is limited to Five Hundred Dollars (\$500) per Plan Year. Replacements for hearing aids are allowed once every two years.

3.1.10 **Acupuncture.** Coverage for acupuncture services is up to a maximum of thirty (30) visits per Plan Year as stated in Exhibit A.

3.1.11 **Chemical dependency treatment.** Coverage for the diagnosis and necessary treatment of chemical dependency shall not be subject to a dollar limit other than being included under the PPACA Annual Limit.

3.1.12 **Chiropractic.** Coverage for chiropractic Services is up to a maximum of thirty (30) visits per Plan Year as stated in Exhibit A.

3.1.13 **Occupational Therapy.** Coverage for Occupational therapy is up to a maximum of twenty (20) visits per Plan Year as stated in Exhibit A.

3.1.14 **Respiratory Assist Devices.** Coverage for Respiratory Assist Devices (RAD) is based upon medical necessity and will be in accordance with published Medicare Guidelines of coverage at the time of service.

§3.2 **Other benefit limitations.** The medical benefits available under this Agreement are subject to the following other benefit limitations, in addition to all other exclusions and limitations set forth in the Agreement and this Certificate, Per Covered Person:

3.2.1 **Emergency Services.** Coverage for Emergency Services is generally limited to those Services required for diagnosis and treatment of an Emergency immediately after onset, no later than twenty-four (24) hours. PPACA Emergency Services shall be provided as necessary to stabilize the Covered Person, without regard to such time limit.

3.2.2 **Hospital and Surgical authorization.** Prior Authorization must be obtained from the Company before a Covered Person is admitted to a Hospital or has one of the Surgeries or Medical Procedures listed in §3.2.2.2. Prior Authorization will be handled in accordance to the MCG Guidelines.

3.2.2.1 **Responsibility for Prior Authorization.** The Participating Provider ordering the hospitalization or Surgery for a Covered Person shall obtain Prior Authorization. The Covered Person shall not be responsible for obtaining Prior Authorization and shall not be liable for any penalty.

The Non-Participating Provider or the Covered Person shall be responsible for obtaining Prior Authorization required by the Company prior to the hospitalization or Surgery. In the event a Covered Person is admitted to a Hospital for an Emergency, required authorization consists of notifying Company (i) within forty eight (48) hours of the admission if it occurs on a day other than a Saturday, Sunday or holiday; or (ii) within seventy-two (72) hours if it occurs on a Saturday, Sunday or holiday, and, in either case, receiving Company's authorization for the admission. PPACA Emergency Services shall not require Prior Authorization, and such services provided by Non-Participating Providers shall not require any notification or other administrative requirement other than what is required when provided by Participating Providers.

Prior Authorization denials shall be handled pursuant to the PPACA Claims Procedure Requirements provided in §5.19, to the extent required by PPACA.

- 3.2.2.2 Reduced benefit without Prior Authorization.** If a required Prior Authorization is not obtained in accordance with this §3.2.2, Company shall pay fifty percent (50%) of the Eligible Charges incurred in connection with the confinement or Surgery. If the Participating Provider is the person required to obtain the Prior Authorization, the reduction in benefits shall not be charged to the Covered Person. No penalty for failure to obtain Prior Authorization shall be imposed for a PPACA Emergency, whether Participating or Non-Participating Providers are utilized.

List of outpatient and inpatient procedures requiring authorization (unless a PPACA Emergency). If the following procedures are not pre-certified by plan, payment may be denied.

- | | | |
|--|---|--|
| • AIDS Treatment | • Congenital treatment | • MIBI Scan, Thallium Stress Test, Exercise Stress Test |
| • All elective outpatient surgical procedures requiring use of surgical facilities | • CPAP machine (durable medical equipment) | • MRI (All) |
| • All out of service area services and procedures | • Durable Medical Equipment: Standard hospital bed, wheelchairs, walkers, crutches, oxygen, suction machine | • Non-Routine Endoscopies and Colonoscopies |
| • Any and all diagnostics and surgical procedures in excess of \$300.00 including specialty laboratory | • EMG/NCT (upper extremities) | • Pain Management Studies |
| • Any back or disc surgery | • End Stage Renal Disease treatment/Hemodialysis | • Physical Therapy requiring more than five (5) out-patient visits |
| • Any knee surgery | • Cardiac Surgery | • Prostatetectomy |
| • Any procedure requiring orthopedic devices and/or prosthetics | • Gall Bladder surgery | • Radiological and nuclear diagnostic procedures performed or ordered by the same provider on any one patient two or more time |
| • Any varicose veins surgery | • Heart By-pass surgery | • Robotic Suite and Robotic Surgery |
| • Breast reconstruction surgery | • Heart Catheterization | • Ultrasounds (All with the exception of the first OB ultrasound & first FNST) |
| • Carpal Tunnel Release | • Hernia Surgery | • Upper GI Endoscopy |
| • Clinical Trials | • Hyperbaric oxygen treatment | • Prosthetic & Orthotic devices as covered by Medicare |
| | • Hysterectomy | |
| | • Mastectomy | |

3.2.3 Excess Non-Participating Provider charges. The Covered Person shall be responsible for charges by a Non-Participating Provider in excess of Eligible Charges, except (a) Out-Of-Service Area emergency, or (b) when the Non-Participating Provider is a Sole Source Provider as defined in §7.9 of the Agreement. A Covered Person using a Non-Participating Provider for a PPACA Emergency shall not be liable for Co-Payments or Co-Insurance in excess of Co-Payments and Co-Insurance that would have been charged if Participating Providers had been used. The Company shall pay an amount for PPACA Emergency Services computed as provided in this Agreement.

3.2.4 Excessive Participating Provider charges. The Covered Person shall not be liable for charges by a Participating Provider in excess of the Eligible Charges.

3.2.5 Physical therapy. Charges for the first twenty (20) visits to a licensed physical therapist for physical therapy, including neuromuscular rehabilitation. After twenty (20) visits in a Plan Year, Company shall pay fifty percent (50%) of Eligible Charges.

3.2.6 Skilled Nursing Facility care. Coverage for Skilled Nursing Facility Services is limited to sixty (60) days maximum per Plan Year.

3.2.7 Case Management. Company may, in its discretion, assign Nurses or other qualified health professionals for the purpose of Case Management. Payment for alternative Services in one instance does not obligate the Company to provide the same or similar benefits for the same or any other Covered Person in any other instance. Payment of these alternative benefits is made as an exception and in no way changes or voids the benefits, terms or conditions of this Agreement.

ARTICLE 4

Specific Exclusions from Benefits

§4.1 No benefits will be paid for Injury or Illness, (a) when the Covered Person is entitled to receive disability benefits or compensation (or forfeits his or her right thereto) under Worker's Compensation or Employer's Liability Law for such Injury or Illness or (b) when Services for an Injury or Illness are rendered to the Covered Person by any federal, state, territorial, municipal or other governmental instrumentality or agency without charge, or (c) when such Services would have been rendered without charge but for the fact that the person is a Covered Person under the Plan.

§4.2 No benefits will be paid if any material statement made in an application for coverage, enrollment of any Dependent or in any claim for benefits is false. Upon identifying any such false statement, Company shall give the Covered Person at least 30 days notice that his or her benefits have been suspended and that his or her coverage is to be terminated. If the false statement is fraudulent or is an intentional misrepresentation of a material fact, such termination shall be retroactive to the date coverage was provided or continued based on such fraudulent statement or intentional misrepresentation of material fact. If the false statement was not a fraudulent statement or intentional misrepresentation of material fact, termination of coverage shall be effective no earlier than the date of the suspension. The Covered Person may dispute any termination of coverage by filing a claim under the PPACA Claims Procedure for internal or external appeals, set out in §6.7 of this Certificate. If an appeal under §6.7 is filed, the resolution of the matter shall be in accordance with the outcome of the appeal proceedings. If no appeal is filed for any retroactive termination and the Company paid benefits prior to learning of any such false statement, the Subscriber must reimburse the Company for such payment. Terminations of coverage shall be handled in accordance with the applicable claims procedure requirements of Section 2719 of the PHSA, as added by PPACA. Retroactive terminations of coverage shall not violate the applicable prohibitions on rescissions of Section 2712 of the PHSA, as added by PPACA, and rescissions shall be handled in compliance with PPACA's applicable claim denial requirements.

§4.3 No benefits will be paid for confinement in a Hospital or in a Skilled Nursing Facility if such confinement is primarily for custodial or domiciliary care. (Custodial or domiciliary care includes that care which consists of training in personal hygiene, routine nursing services and other forms of self care. Custodial or domiciliary care also includes supervisory services by a Physician or Nurse for a person who is not under specific medical or surgical treatment to reduce his or her disability and to enable that person to live outside an institution providing such care.) Company and not Covered Person shall be liable if the Company approves the confinement, regardless of who orders the service.

§4.4 No benefits will be paid for nursing and home health aide services provided outside of the home (such as in conjunction with school, vacation, work or recreational activities)

§4.5 No benefits will be paid for private Duty Nursing. This provision does not apply to Home Health Care.

§4.6 No benefits will be paid for special medical reports, including those not directly related to treatment of the Member. (e.g., Employment or insurance physicals, and reports prepared in connection with litigation.)

§4.7 No benefits will be paid for services required by third parties, including but not limited to, physical examinations, diagnostic services and immunizations in connection with obtaining or continuing employment, obtaining or maintaining any license issued by a municipality, state, or federal government, securing insurance coverage, travel, school admissions or attendance, including examinations required to participate in athletics, except when such examinations are considered to be part of an appropriate schedule of wellness services.

§4.8 No benefits will be paid for court ordered services, or those required by court order as a condition of parole or probation.

§4.9 No benefits will be paid for Services and supplies provided to a Covered Person for an Injury or Illness resulting from an attempted suicide by that Covered Person unless resulting from a medical condition (including physical or mental health conditions) or from domestic violence.

§4.10 No benefits will be paid for Services and supplies provided in connection with intentionally self-induced or intentionally self-inflicted injuries or illnesses unless resulting from a medical condition (including physical or mental conditions) or from domestic violence.

§4.11 No benefits will be paid for Services and supplies provided to a Covered Person for Injuries incurred while the person was committing a criminal act.

§4.12 Unless otherwise specifically provided in the Agreement, no benefit will be paid for, or in connection with, airfare and the Company will not pay for the transportation from Guam to any off-island facility, nor for any other non-medical expenses such as taxes, taxis, hotel rooms, etc. In no event will the Company pay for air ambulance or for the transportation of the remains of any deceased person.

§4.13 No benefits will be paid for living expenses for Covered Persons who require, or who of their own accord seek, treatment in locations removed from their home.

§4.14 No benefits will be paid for home uterine activity monitoring.

§4.15 No benefits will be paid for services performed by an immediate family member for which, in the absence of any health benefits coverage, no charge would be made. Immediate family member is defined as parents, spouses, siblings, or children of the insured member.

§4.16 No benefits will be paid for treatment of occupational injuries and occupational diseases, including those injuries that arise out of (or in the course of) any work for pay or profit, or in any way results from a disease or injury which does. If a Member is covered under a Workers' Compensation law or similar law, and submits proof that the Member is not covered for a particular disease or injury under such law, that disease or injury will be considered "nonoccupational" regardless of cause. The Covered Benefits under the Group Health Insurance Certificate for Members eligible for Workers' Compensation are not designed to duplicate any benefit to which they are entitled under Workers' Compensation Law. All sums payable for Workers' Compensation services provided under the Group Health Insurance Certificate shall be payable to, and retained by Company. Each Member shall complete and submit to Company such consents, releases, assignments and other documents reasonably requested by Company in order to obtain or assure reimbursement under the Workers' Compensation Law

§4.17 No benefits will be paid for:

4.17.1 Drugs or substances not approved by the Food and Drug Administration (FDA), or

4.17.2 Drugs or substances not approved by the FDA for treatment of the illness or injury being treated unless empirical clinical studies have proven the benefits of such drug or substance in treating the illness or injury, or

4.17.3 Drugs or substances labeled "Caution: limited by federal law to investigational use."

4.17.4 Any drug or substance which does not, by federal or state law, require a prescription order (i.e., an over-the-counter (OTC drug).

§4.18 No benefits will be paid for any item or substance that is available without a Physician's prescription even if prescribed by a Physician, except as otherwise provided herein and except for medicines and supplies Medically Necessary for inpatient care.

§4.19 No benefits will be paid for experimental or Investigational Procedures, or ineffective surgical, medical, psychiatric, or dental treatments or procedures, research studies, or other experimental or investigational health care procedures or pharmacological regimes, unless deemed medically necessary by the patient's physician, are associated with a qualifying clinical trial per PPACA regulations, and pre-authorized by the Company.

Per PHSA sec. 2709(a)(2), added by PPACA sec 10103(c), the plan must pay for items and services furnished in connection with approved clinical trials, and cannot exclude such items and services based on an exclusion for experimental or investigational treatments. The requirement mandates coverage of all medically necessary charges associated with the clinical trial, such as physician charges, labs, X-rays, professional fees and other routine medical costs.

An approved clinical trial is defined as:

- Phase I, Phase II, Phase III, or Phase IV clinical trial,
- Being conducted in relation to the prevention, detection or treatment for Cancer or other life threatening disease or condition, and
- Is one of the following:
 1. A federally funded or approved trial.
 2. A clinical trial conducted under an FDA investigational new drug application.
 3. A drug trial that is exempt from the requirement of an FDA investigational new drug application.

§4.20 No benefits will be paid for services or supplies related to Genetic Testing except as may be required by PPACA.

§4.21 No benefits will be paid for any item or substance that is available without a Physician's prescription even if prescribed by a Physician, except as otherwise provided herein and except for medicines and supplies Medically Necessary for inpatient care.

§4.22 No benefits will be paid for Services and supplies provided to perform transsexual surgery or to evaluate the need for such surgery. Evaluations and subsequent medications and Services necessary to maintain transsexual status are also excluded from coverage, as are complications or medical sequela of such surgery or treatment.

§4.23 No benefits will be paid for injuries incurred by the operator of a motorized vehicle while such operator is under the influence of intoxicating alcoholic beverage, controlled drugs, or substances. If a blood alcohol level or the DRAEGER ALCO TEST is available and shows levels that are equal to or exceed 0.08 grams percent (gms%) or that exceed the amount allowed by law as constituting legal intoxication, no benefits will be paid.

§4.24 No benefits will be paid for any medical Service or supply which is available to the Covered Person on Guam and which is paid by or reimbursable through a governmental agency or institution that provides medical and healthcare services to low-income or indigent persons, provided, however, this exclusion *shall* not apply to the treatment of any communicable disease as defined in Article 3 of Chapter 3, Title 10, Guam Code Annotated, and for which the Company *shall* pay for medical services and supplies as is medically necessary for the treatment of Covered Person. However, notwithstanding the aforesaid, in no event will the Company consider the availability of benefits under Medicaid or Medically Indigent Program when paying benefits under this Agreement.

§4.25 No benefits will be paid for dental services including but not limited to, services related to the care, filling, removal or replacement of teeth and treatment of injuries to or diseases of the teeth, dental services related to the gums, apicoectomy (dental root resection), orthodontics, dental splint and other dental appliances, root canal treatment, soft tissue

impactions, alveolectomy, augmentation, and vestibuloplasty, treatment of periodontal disease, false teeth, prosthetic restoration of dental implants, maxillary and mandible implants (osseointegration) and all related services, removal of impacted teeth, bite plates, orthognathic surgery to correct a bit defect. This exclusion does not apply to:

4.25.1 Removal of bony impacted teeth, bone fractures, removal of tumors, and biopsy or excision of oral cysts.

4.25.2 Emergency Services to stabilize an acute injury to sound natural teeth, the jawbone or surrounding structures, if provided within 48 hours of the injury or as required by PPACA to stabilize and treat a PPACA Emergency.

4.25.3 Surgical treatment of TMJ as described in the Covered Benefits Section "Temporomandibular Joint Syndrome (TMJ) Services".

4.25.4 Dental anesthesia when provided according to the conditions described in the Covered Benefits Section, "Limited General Anesthesia for Dental Procedures".

4.25.5 Procedures deemed medically necessary by patient's physician and pre-authorized by Company.

§4.26 No benefits will be paid for vision care services, including orthoptics (a technique of eye exercises designed to correct the visual axes of eyes not properly coordinated for binocular vision), lasik, keratoplasty, and radial keratotomies, including related procedures designed to surgically correct refractive errors except as provided in the Covered Benefits section of the Group Health Insurance Certificate.

§4.27 No benefits will be paid for Services in connection with surgery for the purpose of diagnosing or correcting errors in refraction

§4.28 No benefits will be paid in connection with any injuries sustained while the Covered Person is operating any wheeled vehicle during an organized, off-road, competitive sporting event.

§4.29 No benefits will be paid for personal comfort or convenience items, including those services and supplies not directly related to medical care, such as guest meals and accommodations, barber services, telephone charges, radio and television rentals, homemaker services, travel expenses, take-home supplies.

§4.30 No benefits will be paid for hypnotherapy.

§4.31 No benefits will be paid for religious, marital and sex counseling, including services and treatment related to religious counseling, marital/relationship counseling, and sex therapy.

§4.32 No benefits will be paid for cosmetic Surgery, or other services intended primarily to improve the Member's appearance or treatment relating to the consequences of, or as a result of, Cosmetic Surgery. This exclusion does not apply to:

4.32.1 Medically Necessary reconstructive surgery as described in the Covered Benefits sections Mastectomy and Reconstructive Breast Surgery or Reconstructive Surgery.

4.32.2 surgery to correct the results of injuries causing an impairment;

4.32.3 surgery as a continuation of a staged reconstruction procedure, including but not limited to post-mastectomy reconstruction;

4.32.4 surgery to correct congenital defects necessary to restore normal bodily functions, including but not limited to, cleft lip and cleft palate.

§4.33 Except as otherwise provided in this agreement, no benefit will be paid for specific non-standard allergy services and supplies, including but not limited to, skin titration (winkle method), cytotoxicity testing (Bryan's Test), treatment of non-specific candida sensitivity, and urine autoinjections.

§4.34 No benefits will be paid for Services and supplies associated with growth hormone treatment unless the Covered Person is proven to have growth hormone deficiency using accepted stimulated growth hormone analyses and also shows an accelerated growth response to growth hormone treatment. Under no circumstances will growth hormone treatment be covered to treat short stature in the absence of proven growth hormone deficiency.

§4.35 No benefits will be paid for Services and supplies provided for liposuction.

§4.36 No benefits will be paid for weight reduction programs, or dietary supplements, except as pre-authorized by Company for the Medically Necessary treatment of morbid obesity.

§4.37 No benefits will be paid for any drug, food substitute or supplement or any other product, which is primarily for weight reduction unless medically necessary.

§4.38 Except as provided in this Agreement, or unless medically necessary for the treatment of Morbid Obesity or other disease, no benefit will be paid for gastric bypass, stapling or reversal if for the purpose of weight reduction or aesthetic purposes.

§4.39 No benefits will be paid for surgical operations, procedures or treatment of obesity, except when pre-authorized by Company.

§4.40 No benefits will be paid for the treatment of male or female Infertility, including but not limited to:

4.40.1 The purchase of donor sperm and any charges for the storage of sperm;

4.40.2 The purchase of donor eggs and any charge associated with care of the donor required for donor egg retrievals or transfers or gestational carriers;

4.40.3 Charges associated with cryopreservation or storage of cryopreserved embryos (e.g. office, hospital, ultrasounds, laboratory tests, etc.);

4.40.4 Home ovulation prediction kits;

4.40.5 Injectable Infertility medications, including but not limited to, menotropins, hCG, GnRH agonists, IVIG;

4.40.6 Artificial Insemination, including in vitro fertilization (IVF), gamete intrafallopian tube transfer (GIFT), zygote intrafallopian tube transfer (ZIFT), and intracytoplasmic sperm injection (ICSI), and any advanced reproductive technology ("ART") procedures or services related to such procedures;

4.40.7 Any charges associated with care required for ART (e.g., office, Hospital, ultrasounds, laboratory tests, etc.);

4.40.8 Donor egg retrieval or fees associated with donor egg programs, including but not limited to fees for laboratory tests;

4.40.9 Any charge associated with a frozen embryo transfer including but not limited to thawing charges;

4.40.10 Reversal of sterilization surgery; and

4.40.11 Any charges associated with obtaining sperm for ART procedures.

§4.41 Except as provided in this Agreement, no benefits will be paid for the purchase or rental of durable or disposable medical equipment and supplies, other than for equipment and supplies used in a Hospital or Skilled Nursing Facility, or in conjunction with an approved Hospital or Skilled Nursing Facility confinement, or items covered as preventive care under well-women coverage in accordance with reasonable medical management techniques, or as otherwise noted in the Agreement.

§4.42 No benefits will be paid for household equipment, including but not limited to, the purchase or rental of exercise cycles, water purifiers, hypo-allergenic pillows, mattresses or waterbed, whirlpool or swimming pools, exercise and massage equipment, central or unit air conditioners, air purifiers, humidifiers, dehumidifiers, escalators, elevators, ramps, stair glides, emergency alert equipment, handrails, heat appliances, improvements made to a Member's house or place of business, and adjustments to vehicles.

§4.43 No benefits will be paid for outpatient supplies (except diabetic supplies), including but not limited to, outpatient medical consumable or disposable supplies such as syringes, incontinence pads, and elastic stockings.

§4.44 No benefits will be paid for Services and supplies provided for penile implants of any type.

§4.45 No benefits will be paid for Services and supplies to correct sexual dysfunction.

§4.46 Except as specifically provided, if a benefit is excluded, all Hospital, surgical, medical treatments, prescription drugs, laboratory services, and x-rays in relation to the excluded benefits are also excluded as of the time it is determined that the benefit is excluded.

§4.47 Except as specifically provided in this Agreement, no benefits will be provided for Services and supplies not ordered by a Physician or not Medically Necessary.

§4.48 No benefits will be paid for temporomandibular joint disorder treatment (TMJ) including treatment performed by prosthesis placed directly on the teeth except as covered in the Covered Benefits Section

§4.49 Except as specifically provided in this Agreement, no benefits will be paid for corrective appliances, artificial aids and durable equipment.

§4.50 No benefits will be paid for Services for which the Covered Person or Subscriber is not legally obligated to pay.

§4.51 No benefit will be paid for ambulance services when used for routine and convenience transportation to receive outpatient or inpatient services, unless deemed medically necessary with prior authorization obtained from Company.

§4.52 No benefits will be paid for elective or voluntary enhancement procedures, surgeries, services, supplies and medications including, but not limited to, hair growth, hair removal, hair analysis, sexual performance, athletic performance, anti-aging, and mental performance, even if prescribed by a Physician.

§4.53 No benefits will be paid for hospital take-home drugs.

§4.54 No benefits will be paid for fees for any missed appointments or voluntary transfer of records as requested by the Covered Person.

§4.55 No benefits will be paid for educational services. Special education, including lessons in sign language to instruct a Member, whose ability to speak has been lost or impaired, to function without that ability, are not covered.

§4.56 No benefits will be paid for Intelligence, IQ, aptitude ability, learning disorders, or interest testing not necessary to determine the appropriate treatment of a psychiatric condition.

§4.57 No benefits will be paid for Psychoanalysis or psychotherapy credited toward earning a degree or furtherance of education or training regardless of diagnosis or symptoms or whether providing or receiving the Service.

§4.58 No benefits will be paid for non-medically necessary services, including but not limited to, those services and supplies:

4.58.1 Which are not Medically Necessary, for the diagnosis and treatment of illness, injury, restoration of physiological functions, or covered preventive services;

4.58.2 That do not require the technical skills of a medical, mental health or a dental professional;

4.58.3 Furnished mainly for the personal comfort or convenience of the Member, or any person who cares for the Member, or any person who is part of the Member's family, or any Provider;

4.58.4 Furnished solely because the Member is an inpatient on any day in which the Member's disease or injury could safely and adequately be diagnosed or treated while not confined;

4.58.5 Furnished solely because of the setting if the service or supply could safely and adequately be furnished in a Physician's or a dentist's office or other less costly setting.

§4.59 As required by HIPAA, no source-of-injury exclusion, such as exclusion 4.28 for off-road sporting events, will apply if the accident resulted from an act of domestic violence or a medical condition (including both physical and mental health conditions).

Article V.

General Terms and Conditions

§5.1 **Eligibility.** An individual is eligible for Enrollment and benefits only if he or she satisfies the definition of Covered Person and has not previously had coverage under the Plan which was terminated for cause.

§5.2 **Dependent.** A Dependent is either a:

5.2.1 **Spouse.** The Spouse of the Subscriber includes (i) a lawful wedded spouse; or (ii) a divorced spouse where there is an order issued by a court having jurisdiction over the parties that the Subscriber continue to provide such spouse coverage under this Plan, provided that no Subscriber can enroll more than one (1) person as a spouse at a time unless one spouse is covered pursuant to a court order.

5.2.2 **Domestic Partner.** The Domestic Partner of the Subscriber shall be defined as a person who: (1) is 18 years of age or older; (2) is of the same or opposite sex as Subscriber; (3) is in an exclusive mutually committed relationship with the Subscriber and intends to remain the Subscriber's sole domestic partner; (4) is not married to any other person; (5) is not related to the Subscriber by blood to a degree that would prohibit marriage; and (6) has cohabitated with the Subscriber for the two (2) consecutive years immediately preceding the proposed Enrollment.

§5.3 **Residency Requirement.** Except as otherwise specifically stated in this Agreement, Enrollment in the Plan shall be limited to only those Covered Persons who are Domiciled in the Service Area and do not reside out of the Service Area for more than 182 days per Plan Year. Company shall be entitled to prior notice from the Covered Person concerning his/her residency status and the failure of the Covered Person to provide this prior notice may result in a denial of benefits under this Agreement. Company shall also be entitled to require substantiation from a Covered Person to determine the Covered Person's Domicile and may deny benefits under this Agreement for lack thereof. Covered Persons outside the Service Area must coordinate their care and obtain Prior Authorization from the Company for Services, excluding Emergency services. For a Covered Person who is Domiciled in the Service Area, time spent receiving continuous medical Services out of the Service Area shall not count toward the 182 day maximum provided the receipt of such Services precludes returning to the Service Area. Further, time spent by a parent or spouse of such Covered Person shall not count toward the 182 day maximum, provided the parent or spouse is providing necessary assistance to the Covered Person and further provided that under no circumstance can there be more than one such caregiver hereunder for any incident out of the Service Area.

Company shall use its best efforts, to include making available written forms and materials, to inform Subscribers of the requirements of this Section during enrollment period, in its marketing materials and on its website.

§5.4 Institutionalized applicant. Any individual shall be entitled to the full benefits of this Plan beginning on his or her effective date regardless of any pre-existing medical condition and regardless of whether he or she is confined as an inpatient in any institution. In the event the individual is confined in an inpatient facility covered under this Agreement and incurring costs covered under this Plan, Company will make best efforts to coordinate with the individual's prior carrier, if any, to minimize disruption in the individual's medical care and to minimize cost to the Plan.

§5.5 Enrollment.

5.5.1 Enrollment During an Open Enrollment Period. An eligible individual may enroll in the Plan during an open Enrollment period, or as proscribed by federal or local law to include Section 1882 of the Social Security Act, 42 USC §1395ss.

5.5.2 Enrollment After Open Enrollment Period. Persons becoming eligible for Enrollment after completion of Open Enrollment period under this Agreement may elect to enroll within thirty (30) days of the date of first becoming eligible.

5.5.3 After Thirty (30) Day Enrollment

5.5.3.1 Subscriber. Subject to §5.5.3.3, an individual eligible to enroll as a Subscriber who does not make written election for Enrollment within thirty (30) days after first becoming eligible shall not be permitted to enroll hereunder until the next Open Enrollment period unless entitled to special enrollment rights under federal or local law.

5.5.3.2 Dependents. Subject to §5.5.3.3, a Subscriber with Dependents eligible for Enrollment who does not make written election for Enrollment of such Dependents within thirty (30) days after their first becoming eligible shall not be permitted to enroll such Dependents hereunder until the next Open Enrollment period unless entitled to special enrollment rights under federal or local law.

5.5.3.3 HIPAA and PPACA Enrollment Requirements. If an individual eligible to enroll as a Subscriber loses other employer coverage or acquires a Dependent through marriage, then the special enrollment requirements of HIPAA may be applicable. If a Subscriber becomes eligible for a HIPAA special enrollment, such Subscriber and Spouse, if applicable, shall be entitled to change from Class I to Class II during such special enrollment.

§5.6 Commencement of coverage. After fulfilling all conditions of Enrollment as set out in this Agreement, coverage under the Plan shall commence:

5.6.1 Previously Enrolled. As of the Effective Date of this Agreement, for a Subscriber and his or her Covered Dependents who are Enrolled on such Effective Date.

5.6.2 Not Yet Enrolled. As of the first day following the pay period in which the individual satisfies the Enrollment requirements as set forth in this Agreement and Company becomes entitled to receive the appropriate Premium for a Subscriber and his or her Covered Dependents who become Enrolled subsequent to the Effective Date of this Agreement.

5.6.3 Except as provided in §5.6, coverage of a Dependent of a Subscriber who become eligible after such Subscriber has been Enrolled hereunder shall commence as of the first day of the pay period following the timely filing of an application for Enrollment and liability for the appropriate Premium accrues.

5.6.4 Open Enrollment Period. For any eligible individual and his or her eligible Dependent who applies for Enrollment or re-Enrollment during GovGuam's open Enrollment period, coverage shall commence as of the Plan effective date first following the open Enrollment.

§5.7 Continuing Enrollment. Subscribers and Covered Dependents enrolled under this Plan on the last day of a Plan Year shall be automatically enrolled for the following Plan Year unless they change to some Other Plan during open Enrollment or unless this Plan is not renewed.

§5.8 Medical Term. Covered Persons must continue medical coverage under this Agreement for a minimum of twelve (12) months or for the balance of the Plan Year, except when termination of Enrollment is approved by GovGuam's Director of Administration and by Company. A rate increase during the Plan Year is not grounds for disenrollment.

§5.9 Dental eligibility and term. Covered Persons may enroll in the Company's dental plan only if they are enrolled in Company's Retiree Supplement Insurance Plan. Covered Persons in the medical and dental Plan must continue their medical and dental coverage under this Agreement for a minimum of twelve (12) months or for the balance of the Plan Year, except when termination of Enrollment is approved by GovGuam's Director of Administration and by Company. A rate increase during the Plan Year is not grounds for disenrollment.

§5.10 Release of medical information. As a condition to the receipt of Plan benefits, each Covered Person authorizes Company to use and obtain information about his or her medical history, medical condition and the Services provided to him or her as may be necessary in connection with the administration of this Agreement. Information from medical records of Covered Persons and information received from Physicians or Hospitals arising from the Physician-patient relationship shall be kept confidential and shall only be disclosed with the consent of the Covered Person and in accordance with applicable law.

§5.11 Termination for cause. Company may terminate a Covered Person from the Plan for:

5.11.1 Misuse of card. A Covered Person knowingly allowing his or her Plan identity card to be used by another person or falsely representing the relation between himself or herself and another in order that the other person can obtain Services hereunder; or

5.11.2 To the extent required by PPACA, terminations for cause (other than for non-payment of premiums) shall be handled as required by the applicable PPACA Claims Procedure Requirements provided in §5.19 and as reflected in the Company's Appeal Procedures.

§5.12 Termination other than for cause. Except as otherwise provided in this Agreement or applicable law, if the Covered Person terminates his or her rights under this Agreement then all rights to benefits shall cease as of the effective date of such termination. However, Company shall pay Eligible Charges for all Covered Services incurred prior to the date of termination.

§5.13 Rebate of Premium. In the event of termination of coverage, GovGuam or the Subscriber, as applicable, shall receive a pro rata rebate of the Premium paid to Company for such Covered Person.

§5.14 Effective date of termination. Except as otherwise provided herein, termination of coverage shall take effect on the first (1st) day of the pay period following the event causing termination.

§5.15 To the extent required by PPACA, disputed terminations (other than for non-payment of premiums) shall be handled as required by the applicable PPACA claims procedure rules for external review process that provides the right to appeal within four (4) months after you receive notice of termination. A Covered Person can appeal a disputed termination pursuant to the PPACA Claims Procedure for internal and external review appeals provided in §5.19.

§5.16 HIPAA compliance. Company shall provide the certifications required by HIPAA for terminated Subscribers upon notification by GovGuam of the Subscriber's termination.

§5.17 Grievance Procedures. The Grievance Procedure is not applicable to adverse benefit determinations, including rescission of coverage, and their appeals which are subject to PPACA Claims Procedure Requirements provided in §5.20 and reflected in the Company's Appeal Procedures. A grievance is a formal complaint or dissatisfaction with the service received by a Covered Person. Grievance includes complaints about the quality of care or non-quality of care services at any of the Company's contracted network facilities, providers or with any administration provider/behavioral services and access to care. Non-quality of care services includes complaints about administrative services, sales processes or other marketing issues. A Covered Person and/or his or her representative may file a written grievance claim, including all relevant documentation, with the Company. The Covered Person and Company shall provide additional information or documentation, as applicable, if requested in writing.

5.17.1 Within sixty (60) days after a grievance is received by the Company, the Covered Person shall be notified in writing of the denial, partial denial or approval of the grievance.

5.17.2 If a Covered Person does not agree with the decision, then the Covered Person or the Covered Person's authorized representative may file a grievance appeal as follows:

5.17.2.1 A written grievance appeal request must be directed to the Grievance Coordinator. The request shall state all bases for the grievance appeal and be supported by all relevant information and documentation.

5.17.2.2 The Grievance Coordinator may refer grievance appeals to the medical society, the utilization department, peer review committee, or a medical specialty organization for an opinion to assist in the resolution of the grievance appeal.

5.17.2.3 Within ten (10) working days of the receipt of a grievance appeal, the Grievance Coordinator shall be available to meet with the Covered Person to discuss possible resolution of the matter and establish the time frame for review of the grievance appeal, which shall not exceed thirty (30) days.

§5.18 Notice. For purposes of service of any notice or other document under this Agreement, a Covered Person's address shall be that stated in the Enrollment materials, unless the Covered Person designates a new address by providing written notice to the Company. The address of the Company is: unless the Company designates a new address in writing served on the Covered Person.

§5.19 Cooperation Regarding Federal Law. Company and the Government of Guam shall fully cooperate in implementing any Qualified Medical Child Support Order as defined and required by federal law.

§5.20 PPACA Claims Procedure Requirements. Adverse benefit determinations, including rescissions of coverage, and their appeals are subject to the requirements of Section 2719 of the PHSA, as added by PPACA, and applicable regulations to include 45 CFR 147.136 and 29 CFR 2560.503-1. The term "adverse benefit determination" means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant's or beneficiary's eligibility to participate in a plan (e.g., a rescission of coverage), and including, with respect to group health plans, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate. The Company's PPACA Claims Procedure is reflected in Exhibit F.

5.20.1 As required by PPACA, the Company shall comply with U.S. Department of Labor claims regulations applicable to health plans under the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), as set forth at Section 2560.503-1 of Title 29, Code of Federal Regulations, as such regulations may be updated from time to time by the Secretary of Labor (the "ERISA Claims Regulations"). These ERISA Claims Regulations shall apply notwithstanding that the Plan is a government plan, previously not subject to ERISA's requirements, but shall be modified as follows:

5.20.1.1 An adverse benefit decision, to which the ERISA Claims Regulations shall apply, shall include a rescission, whether or not the rescission has an adverse effect on any particular benefit at that time.

2.20.1.2 In the case of a claim determination (whether adverse or not) involving urgent care, the claimant shall be notified as soon as possible, taking into account the medical exigencies, but not later than 72 hours after the receipt of the claim, unless the claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the plan.

5.20.2 On appeal, the claimant must be allowed to review the claim file and to present evidence and testimony.

5.20.3 Other aspects of the PPACA Claims Procedure regulations shall be followed including the right of a Covered Person to file an external review within four (4) months after the Covered Person receives notice of adverse benefit determination or denial of an internal appeal from the Company.

Article VI.

Dental Benefits

6.1 **Dental Benefits Available.** This Article contains the Dental Benefits available to Covered Persons in the optional dental plan.

6.2 **Definitions.** The definitions contained herein are supplemental to those contained elsewhere in this Agreement and apply only to Dental Benefits in the dental plan. The definitions contained elsewhere in this Agreement are applicable to this Article.

6.2.1 **Treatment Plan.** Treatment Plan means a Dentist's report of the Covered Person's dental defects, prescribing a program of treatment for the identified defects, including applicable charges.

6.3 **Maximum Allowances.** The maximum dental benefit payable by the Company for each Covered Person shall be One Thousand Dollars (\$1,000) per Plan Year.

6.4 Co-Payments for Diagnostic and Preventive Services.

6.4.1 For any Diagnostic and Preventive Services which are covered under §7.7.1 of this Agreement, Company will pay 100% of Eligible Charges if the Services are rendered by a Participating Provider.

6.4.2 For any Diagnostic and Preventive Services which are covered under §7.7.1 of this Agreement, Company will pay 70% of Eligible Charges if the Services are rendered by a Non-Participating Provider.

6.5 Payments for Basic and Restorative Services.

6.5.1 For any Basic and Restorative Services which are covered under §7.7.2 of this Agreement, Company will pay 80% of Eligible Charges if the Services are rendered by a Participating Provider.

6.5.2 For any Basic and Restorative Services which are covered under §7.7.2 of this Agreement, Company will pay 70% of Eligible Charges if the Services are rendered by a Non-Participating Provider.

6.6 Payments for Major and Replacement Services.

6.6.1 For any Major and Replacement Services which are covered under §7.7.3 of this Agreement, Company will pay 50% of Eligible Charges if the Services are rendered by a Participating Provider.

6.6.2 For any Major and Replacement Services, which are covered under §7.7.3 of this Agreement, Company will pay 35% of Eligible Charges if the Services are rendered by a Non-Participating Provider.

6.7 **Services Available.** Subject to the other conditions contained in this Agreement, Covered Persons choosing the optional dental plan for whom Premiums have been paid shall be entitled to the following Dental Benefits:

6.7.1 Diagnostic and Preventive Services.

6.7.1.1 Examinations (including Treatment Plan) limited to once every six (6) months.

6.7.1.2 Radiographs (X-rays).

6.7.1.2.1 Full mouth series (once per 36 months).

6.7.1.2.2 Bite-wings. Maximum of four per Plan Year.

6.7.1.3 Prophylaxis (cleaning and polishing) limited to twice per Plan Year.

6.7.1.4 Topical application of fluoride (once every Plan Year for Covered Persons under the age of 19);

6.7.1.5 Study models.

6.7.1.6 Space maintainers (for Covered Persons age 15 and under). This includes adjustments within 6 months of installation.

6.7.1.7 Caries susceptibility test.

6.7.1.8 Sealants (for permanent molars of Covered Persons age 15 and under).

6.7.2 Basic and Restorative Services.

6.7.2.1 Emergency Services (during office hours).

6.7.2.2 Pulp treatment.

6.7.3.3 Routine fillings (amalgam and composite resin).

6.7.3.4 Simple extractions.

6.7.3.5 Complicated extractions.

6.7.3.6 Extraction of impacted teeth.

6.7.3.7 Periodontal prophylaxis (cleaning and polishing once every six months).

6.7.3.8 Periodontal treatment.

6.7.3.9 Pulpotomy and root canals (endodontic surgery and care).

6.7.3.10 Conscious sedation and nitrous oxide for Covered Persons under the age of 13.

6.7.3 Major Dental Services and Replacement Services.

6.7.3.1 Fixed prosthetics.

6.7.3.1.1 Crowns and bridges.

6.7.3.1.2 Gold inlays and onlays.

6.7.3.1.3 Repairs of crowns and bridges.

6.7.3.1.4 Replacement of crown or bridge (limited to once every five years)

6.7.3.2 Removable prosthetics.

6.7.3.2.1 Full and partial dentures. Replacements limited to once every five years.

6.7.3.2.2 Denture repair and relines.

6.7.3.3 General anesthesia, but only if medically or dentally necessary.

6.8 Claims and Payment for Services. The procedures, requirements and conditions applicable to the processing and payment of claims for Medical Benefits contained in Article 6 shall apply to claims for Dental Services under this Agreement, except the Deductible amount does not apply to the Dental Benefits.

6.9 Reasonableness and necessity of Services and charges.

6.9.1 Company shall not be required to pay any claim unless and until Company has determined that the Covered Person received Covered Services and that the charges for the Dental Services are reasonable. No payment shall be made for: (i) Dental Services not actually rendered; or (ii) Dental Services which are not Covered Services. No payment shall be made for any portion of a charge determined by Company to be unnecessary, unreasonable or excessive. In the case of a Participating Provider, when a Covered Person receives Covered Services, Company guarantees the Covered Person shall not be responsible for payment of any charges in excess of the Eligible Charges

6.9.2 Preliminary determination that any Dental Service or charge is unnecessary or unreasonable or otherwise not payable shall, at the Dentist's or Covered Person's request, be reviewed through Company's grievance procedure. The determination made through the grievance procedure shall be conclusive upon all parties in interest, subject, however to the parties' right to arbitration.

6.10 Prior Authorization of Services. Prior Authorization by Company for Dental Services shall be required when any Treatment Plan and/or treatments exceed Five Hundred Dollars (\$500).

6.11 General Provisions.

6.11.1 Dental Exclusions. No benefits will be paid for:

6.11.1.1 Work in progress on the effective date of coverage. Work in progress is defined as:

6.11.1.1.1 A prosthetic or other appliance, or modification of one, where an impression was made before the patient was covered.

6.11.1.1.2 A crown, bridge, or cast restoration for which the tooth was prepared before the patient was covered.

6.11.1.1.3 Root canal therapy, if the pump chamber was opened before the patient was covered.

6.11.1.2 Services not specifically listed in the Agreement, Services not prescribed, performed or supervised by a Dentist, Services which are not medically or dentally necessary or customarily performed, Services that are not indicated because they have a limited or

poor prognosis, or Services for which there is a less expensive, professionally acceptable alternative.

- 6.11.1.3 Any Service unless required and rendered in accordance with accepted standards of dental practice.
- 6.11.1.4 A crown, cast restoration, denture or fixed bridge or addition of teeth to one, if work involves a replacement or modification of a crown, cast restoration, denture or bridge installed less than five years ago or one that replaces a tooth that was missing before the date of the Covered Person became eligible for Services under the plan (including previously extracted missing teeth).
- 6.11.1.5 Replacement of existing dentures, crowns or fixed bridgework if the existing dentures, crowns or fixed bridgework can be made serviceable
- 6.11.1.6 Precision attachments, Interlocking device, one component of which is fixed to an abutment or abutments the other is integrated into a fixed or removable prosthesis in order to stabilize and/or retain it; or stress breakers, part of a tooth borne and/or tissue-borne prosthesis designed to relieve the abutment teeth and their supporting tissues from harmful stresses.
- 6.11.1.7 Replacement of any lost or stolen appliance, or replacement of any appliance damaged while not in the mouth.
- 6.11.1.8 Any Service for which the Covered Person received benefits under any other coverage offered by the Company.
- 6.11.1.9 Spare or duplicate prosthetic devices.
- 6.11.1.10 Services included, related to, or required for:
 - 6.11.1.10.1 Implants;
 - 6.11.1.10.2 Cosmetic purposes;
 - 6.11.1.10.3 Services or appliances to change the vertical dimension or to restore or maintain the occlusion, including but not limited to, equilibrium, full mouth rehabilitation and restoration for malalignment of teeth;
 - 6.11.1.10.4 Temporomandibular joint (TMJ) or craniomandibular disorders, myofunctional therapy or the correction of harmful habits;
 - 6.11.1.10.5 Experimental procedures; and
 - 6.11.1.10.6 Intentionally self inflicted injury unless resulting from a medical condition (including physical or mental conditions) or from domestic violence.
- 6.11.1.11 Any over the counter drugs or medicine.
- 6.11.1.12 Fluoride varnish.
- 6.11.1.13 Charges for finance charges, broken appointments, completion of insurance forms or reports, providing records, oral hygiene instruction, pit and fissure sealants and dietary instruction, or lack of cooperation on the part of the patient.

- 6.11.1.14 Charges in excess of the amount allowed by the Plan for a Covered Service.
- 6.11.1.15 Any treatment, material, or supplies which are for orthodontic treatment, including extractions for orthodontics.
- 6.11.1.16 Services for which no charge would have been made had the Agreement not been in effect.
- 6.11.1.17 All treatments not specifically stated as being covered.
- 6.11.1.18 Surgical grafting procedures.
- 6.11.1.19 General anesthetic, conscious sedation, and other forms of relative analgesia, except as otherwise specifically provided herein.
- 6.11.1.20 Services paid for by Workers' Compensation.
- 6.11.1.21 Charges incurred while confined as an inpatient in a Hospital unless such charges would have been covered had treatment been rendered in a dental office.
- 6.11.1.22 Treatment and/or removal of oral tumors.
- 6.11.1.23 All surgical procedures except for surgical extractions of teeth and periodontal surgeries Performed by a Dentist. Surgical procedure is defined as the surgical and adjunctive treatment of diseases, injuries, and deformities of the oral and maxillofacial region.
- 6.11.1.24 Panoramic x-ray if provided less than three (3) years from the Covered Person's last full mouth x-rays; and full mouth x-rays if provided less than three (3) years from the Covered Person's last panoramic x-ray.

6.11.2 Issuance of this Agreement. This Article 7 shall take effect, and coverage for the Subscriber and Dependents initially listed on the Enrollment form shall commence as of the Subscriber's Effective Date if the Enrollment form is accepted by Company.

6.11.3 DENTAL COVERAGE SPECIAL CONDITIONS OF ENROLLMENT. EMPLOYEES MAY ELECT TO ENROLL IN THE MEDICAL PLAN ONLY BENEFIT LEVEL OR IN THE MEDICAL AND DENTAL PLAN BENEFIT LEVEL. MEMBERS ENROLLED IN THE MEDICAL PLAN ONLY BENEFIT LEVEL MAY ELECT TO ENROLL IN THE MEDICAL AND DENTAL PLAN DURING ANY OPEN ENROLLMENT PERIOD. ANY COVERED PERSON SELECTING THE MEDICAL AND DENTAL PLAN BENEFIT LEVEL SHALL ENROLL IN THE SAME CLASS FOR THE MEDICAL PLAN AND THE DENTAL PLAN.

Article VII.

Rate.

The Rate for this GovGuam Retiree Supplement Insurance Plan to include the services and benefits set out in Exhibit A and Exhibit B shall be for the semi-monthly rate of \$181.00 for Class I and \$361.50 for Class II effective October 1, 2017 through September 30, 2018, and the optional Dental Plan shall be for the semi-monthly rate of \$17.00 for Class I and \$38.50 for Class II effective October 1, 2017 through September 30, 2018.

EXHIBIT A

GovGuam Retiree Supplemental Plan Schedule of Benefits

Your Benefits: What your plan covers	When you go to participating provider Retiree Supp Plan pays ¹	When you go to participating provider Member pays
Any Services in the Philippines, Hawaii, U.S. Mainland, and any foreign participating providers. (Pre-Certification Required)	Requires a referral from your doctor and approval in advance from the plan	
	Retiree Supplemental Plan pays	Member pays
Preventative Services (Out-Patient Only) Includes Annual Preventive Exams and Preventive Lab Services (Guam and Philippines only) In accordance with the guidelines established by the U.S. Preventive Services Task Force (USPSTF) Grades A and B recommendations	Nothing	Nothing
Immunizations/Vaccinations In accordance with the guidelines established by the Advisory Committee on Immunization Practices	Nothing	Nothing
Well-Woman Care In accordance with the guidelines supported by the Health Resources and Services Administration (HRSA)	Nothing	Nothing
	Retiree Supplemental Plan pays ¹	Member pays
Annual Eye Exam Once per Member per Plan Year	Nothing	Nothing
Outpatient Physician Care & Services 1. Primary Care Visits 2. Specialist Care Visits 3. Voluntary Second Surgical Opinion 4. Mental Health Care 5. Home Health Care Visit 6. Hospice Care in Guam only, maximum 180 days 7. Urgent Care 8. Outpatient Laboratory 9. X-Ray Services 10. Injections (Does not include those on the Specialty Drugs List and Orthopedic injections)	20% co-insurance 20% co-insurance 20% co-insurance 20% co-insurance Nothing 20% co-insurance Medicare Part B deductible Then 20% co-insurance Nothing Medicare Part B deductible Then 20% co-insurance 20% co-insurance	Nothing Nothing Nothing Nothing Nothing Nothing Nothing Nothing Nothing Nothing Nothing Nothing
Prescription Drugs 1. Formulary generic drugs per prescription unit 2. Formulary brand name drugs per prescription unit 3. Mail Order 4. Non-Formulary (Medically Necessary Only and Pre-Certification Required) 5. Specialty Drugs (Medically Necessary Only and Pre-Certification Required)	Plan pays 100% after member co-payment Plan pays 100% after member co-payment Plan pays 100% after member co-payment Plan pays 100% after member co-payment Plan pays 100% after member co-payment	\$15 Member Co-Pay (30 day supply) \$30 Member Co-Pay (30 day supply) Nothing \$60 Member Co-Pay (30 day supply) \$100 Member Co-Pay (30 day supply)

	Retiree Supp Plan pays Eligible charges after Member share ¹	When you go to participating provider Member pays after deductible
Acupuncture 30 visits per member per plan year	Plan pays 80%	Member pays 20%
AIDS Treatment Exclusive of Experimental drugs	Plan pays 80%	Member pays 20%
Airfare Benefit to Centers of Excellence only For members who meet qualifying conditions, Plan provides roundtrip airfare (Plan Approval Required)	Plan pays 100%	Nothing
Allergy Testing \$1000 per member per plan year	Plan pays 80%	Member pays 20%
Ambulatory Surgi-center Care (Pre-Certification Required)	Plan pays 80%	Member pays 20%
Blood & Blood Derivatives	Plan pays 80%	Member pays 20%
Breast Reconstructive Surgery (In accordance with 1998 W.H.C.R.A)	Plan pays 80%	Member pays 20%
Cardiac Surgery	Plan pays 80%	Member pays 20%
Cataract Surgery Outpatient Only (including conventional lens)	Plan pays 80%	Member pays 20%
Chemical Dependency	Plan pays 80%	Member pays 20%
Chemotherapy Benefit	Plan pays 80%	Member pays 20%
Chiropractic Care 30 visits per member per plan year	Plan pays 80%	Member pays 20%
Congenital Anomaly Diseases Coverage	Plan pays 80%	Member pays 20%
Diagnostic Testing MRI, CT scan, and other diagnostic procedures (Pre-Certification Required)	Plan pays 80%	Member pays 20%
Durable Medical Equipment (DME) The lesser amount between the Purchase or Rental of crutches, walkers, wheelchairs, hospital beds, , standard CPAP machine suction machines, nebulizer machine, or oxygen and accessories when prescribed by a Physician (Pre-Certification Required)	Plan pays 80%	Member pays 20% of the total rental cost or purchase
Elective Surgery (Pre-Certification Required)	Plan pays 80%	Member pays 20%
Emergency Care 1. On/Off Island emergency facility, physician services, laboratory, X-rays 2. Ambulance Services (Ground Transportation Only) For off-island emergencies, Plan must be contacted and advised within 48 hours	Plan pays 80%	Member pays 20%
End Stage Renal Disease / Hemodialysis	Plan pays 80%	Member pays 20%
Hearing Aids Maximum \$500 per member per plan year	Plan pays 80%	Member pays 20%
Hospitalization & Inpatient Benefits 1. Room & Board for a semi-private room, intensive care, coronary care and surgery 2. All other inpatient hospital services including laboratory, x-ray, operating room, anesthesia and medication 3. Physician's hospital services	Plan pays 80%	Member pays 20%
Implants Limited to cardiac pacemakers, heart valves, stents, Intraocular lenses, orthopedic internal prosthetic devices (Limitations apply, please refer to contract)	Plan pays 80%	Member pays 20%

Inhalation Therapy	Plan pays 80%	Member pays 20%
Nuclear Medicine (Pre-Certification Required)	Plan pays 80%	Member pays 20%
Occupational Therapy 20 Visits per Plan Year (Pre-Certification Required)	Plan pays 80%	Member pays 20%
Organ Transplant – including, but not limited to: Heart, Lung, Liver, Kidney, Pancreas, Intestine, Bone Marrow and Cornea. Donor expenses are covered. (Pre-Certification Required)	Plan pays 80%	Member pays 20%
Orthopedic Conditions Internal and External Prosthesis	Plan pays 80%	Member pays 20%
Physical Therapy (Pre-Certification Required)	Plan pays 80% for the first 20 visits and 50% thereafter	Member pays 20% for the first 20 visits and 50% thereafter
Radiation Therapy (Pre-Certification Required)	Plan pays 80%	Member pays 20%
Robotic Surgery/Robotics Suite (Pre-Certification Required)	Plan pays 80%	Member pays 20%
Skilled Nursing Facility Maximum 60 days per member per plan year (Pre-Certification Required)	Plan pays 80%	Member pays 20%
Sleep Apnea Diagnostics and Therapeutic Procedure (Pre-Certification Required)	Plan pays 80%	Member pays 20%
Sterilization Procedures Vasectomy (Outpatient Only)	Plan pays 80%	Member pays 20%
Vision Care – Hardware up to \$150	Plan pays 100%	Nothing
Additional Benefits: What the Plan Covers		
Wellness and Fitness Benefit		
Wellness Benefit at a Wellness Center (Pre-Certification Required) 1. Dr. Horinouchi's Wellness Center 2. Guam SDA Wellness Center	Plan pays 80% of the first \$200 Plan pays 50% of charges thereafter	Member pays 20% of the first \$200
Fitness Benefit 1. Custom Fitness 2. Paradise Fitness Center 3. Synergy Studios 4. Unified	Plan pays 100%	Nothing

¹ If a benefit is covered by Medicare, the RSP will cover the Part A or B deductible and the 20% coinsurance. If a benefit is NOT COVERED by Medicare, the plan will cover the percentage indicated on the Schedule of Benefits.

Exhibit B

GOVERNMENT OF GUAM DENTAL

Your Benefits (subject to the specific limitations which are contained in the Group Health Certificate):

are contained in the Group Health Certificate):	Participating Providers	Non-Participating Providers
DIAGNOSTIC & PREVENTIVE CARE 1. Caries Susceptibility Test 2. Exams (including Treatment Plan) (Once every 6 months) 3. Fluoride Treatment (Annually for children age 19 & under) 4. Prophylaxis (Cleaning and polishing of teeth) once every 6 months 5. Sealants (For permanent molars of children age 15 & under) 6. Space maintainers (For children age 15 & under) includes adjustments within 6 months of installation 7. Study Models 8. X-rays (Bite Wing Maximum of 4 per Plan Year) 9. X-rays (Full Mouth, once every 3 years)	100% of Eligible Expenses	70% of Eligible Expenses
BASIC & RESTORATIVE CARE General Services 1. Emergency Services (during office hours). 2. Pulp Treatment. 3. Routine Fillings (amalgam and composite resin). 4. Simple Extractions. 5. Complicated Extractions. 6. Extraction of impacted teeth. 7. Periodontal Prophylaxis (cleaning and polishing once every six months) 8. Periodontal Treatment 9. Pulpotomy & Root Canals/Endodontic Surgery & Care 10. Conscious Sedation and Nitrous Oxide for children under the age of 13.	80% of Eligible Expenses	70% of Eligible Expenses
MAJOR & REPLACEMENT CARE Fixed Prosthetics 1. Crowns and Bridges 2. Gold Inlays & Onlays 3. Replacement of Crown Restoration (limited once every 5 years) Removable Prosthetics 1. Full Dentures (Once every 5 years) 2. Partial Dentures (Once every 5 years) 3. Each anesthesia, but only if medically or dentally necessary 4. Relines 5. Denture Repair	50% of Eligible Expenses	35% of Eligible Expenses
Deductible	None	None
Registration Fee per visit to Dentist	None	None
Coverage Maximums Per Member per Plan Year	\$1,000	
Terms: 1. Unused balances are not transferable to the following year. 2. Charges for Non-participating Providers are limited to the lesser of actual charges or the Company's determination of the usual, customary and reasonable charge in geographic location where the service was rendered, unless otherwise provided in the agreement. 3. The Covered member pays any excess above Eligible Charges.		

Exhibit C

Health and Wellness Rewards

Members can participate in multiple wellness incentive programs that will allow them to earn up to a maximum of \$200 per self only enrollment or \$400 per self and family enrollment for the benefit year. Incentive amounts will be calculated 60 days after the end of the policy or contract period or year, and payment will be made within 30 days after the calculation date. Members must complete a claim reimbursement form and submit to Calvo's SelectCare along with proper documentation in order to claim benefit. Services must be provided by a Participating Provider.

Wellness Rewards	
Criteria/Requirement	Member Incentive
Completion of the SelectCare Online Health Risk Assessment (HRA) by covered adults, age 18 and older, once per benefit year.	\$25
Completion of biometric screening (weight, blood pressure, glucose, cholesterol and BMI) by covered adults, age 18 and older, once per benefit year.	\$25
Annual physician office visit for diabetes with HgbA1c testing by covered individuals with Diabetes Type 2, once per benefit year.	\$25
Annual physician office visit with LDL-C testing for conditions with high-cholesterol by adults, age 18 and older, once per benefit year.	\$25
Annual physician office visit for women, ages 42-69, for breast cancer and screening mammogram once per benefit year.	\$25
Annual physician office visit for colorectal cancer for ages 50 and above with any of the following services: colonoscopy or sigmoidoscopy once per benefit year.	\$25
Annual physician office visit for cervical cancer for women, ages 21-64, with pap smear once per benefit year.	\$25
Completion of SelectCare's Smoking Cessation Program by adults, age 18 and older, once per benefit year.	\$25

Gym/ Fitness Rewards

Calvo's SelectCare Gym/ Fitness Reward Program will reward members \$25 per month for using a Calvo's SelectCare Gym/ Fitness Partner at least 10 days per month for three (3) consecutive months during a GovGuam quarter.

Members may enjoy exclusive no-cost memberships at several Gym/ Fitness partners (Must be 18 yrs. or older).

To earn the Gym/Fitness Reward, members must complete the following requirements:

- Enroll and complete the Calvo's SelectCare online Health Risk Assessment
- Select from one of our gym/ fitness partners
- Work out at least ten (10) days per month at the selected gym/ fitness partner
- Get your gym/ fitness validation card stamped each day you work out
- Accumulate a completed gym/ fitness validation card each month, for three (3) consecutive months each GovGuam quarter
- GOVGUAM Quarters: October to December, January to March, April to June, July to September
- Submit completed gym/ fitness validation cards to our administrative office
- Gym/ fitness validation cards must be submitted to us not later than sixty (60) days after the end of each quarter
- Rewards will be paid within 60 days from the proper submission of the Gym/ Fitness Cards

Exhibit D

2017 Recommended Adult Immunization Schedule

Figure 1. Recommended immunization schedule for adults aged 19 years or older by age group, United States, 2017

Vaccine	19–21 years	22–26 years	27–59 years	60–64 years	≥ 65 years
Influenza ¹	1 dose annually				
Td/Tdap ²	Substitute Tdap for Td once, then Td booster every 10 yrs				
MMR ³	1 or 2 doses depending on indication				
VAR ⁴	2 doses				
HZV ⁵				1 dose	
HPV–Female ⁶	3 doses				
HPV–Male ⁶	3 doses				
PCV13 ⁷					1 dose
PPSV23 ⁷	1 or 2 doses depending on indication				1 dose
HepA ⁸	2 or 3 doses depending on vaccine				
HepB ⁹	3 doses				
MenACWY or MPSV4 ¹⁰	1 or more doses depending on indication				
MenB ¹⁰	2 or 3 doses depending on vaccine				
Hib ¹¹	1 or 3 doses depending on indication				



Recommended for adults who meet the age requirement, lack documentation of vaccination, or lack evidence of past infection



Recommended for adults with additional medical conditions or other indications



No recommendation

For more information, please visit: <https://www.cdc.gov/vaccines/schedules/hcp/adult.html>

Exhibit E
Performance Guarantees

Fees At Risk		Metric	FY18 Guam
Claim Adjudication / Administration			
1.b	\$ 5,000	Clean Claim Timeliness - 45 Calendar Days	99% in 45 days
1.c	\$ 5,000	Claims Financial Accuracy	≥ 98%
1.d	\$ 15,000	Claims Payment Accuracy	≥ 98%
Total	\$ 25,000		
Client/Member Service			
2.a	\$ 5,000	Average Speed to Answer	100% of calls within 30 seconds
2.b	\$ 10,000	Ongoing ID Cards Issuance	99% will be mailed within 15 business days
2.c	\$ 10,000	Member Satisfaction	≥ 85% based on Unit Level
2.d	\$ 5,000	Call Abandonment Rate	≤ 2%
2.e	\$ 5,000	First Call Resolution	≥ 90%
2.f	\$ 10,000	Processing of Ongoing Eligibility Information	100% within 3 business days
2.g	\$ 5,000	Participant Email Response Performance	90% of emails will be responded within 3 days
Total	\$ 50,000		
Account Management			
3.a	\$ 10,000	Account Management Satisfaction	Average score of 3 or higher out of 5
3.b	\$ 10,000	Account Management Reporting	< 15 business days
3.c	\$ 10,000	Account Management Issues Resolution	< 1 business days
Total	\$ 30,000		
Total	\$ 105,000		

Exhibit F

PPACA Claims Procedure

Title 29 C.F.R. § 2560.503-1 and 45 C.F.R. § 147.136 are incorporated herein. Please see the following:

How it Works: The Internal Appeal Process

The federal health care reform law, known as the Affordable Care Act (ACA), ensures you have certain rights if your health insurer denies your claim. These rights make the process of appealing the insurer's decision more transparent, accountable, and fair.

There are two stages of appeals you can choose to pursue if your claim is denied: an internal appeal and an external review. In most cases, you must request an internal appeal before you can request an external review.

What is an internal appeal?

In an internal appeal, also known as a grievance procedure, an insurer reviews its decision to deny coverage for your claim. The ACA requires insurers to adhere to a strict timeline and provide detailed and complete information to you for free about their reason for denying your claim.

If at any point your insurer does not fulfill its obligations in the internal appeals process, you may immediately file an external appeal.

While your internal appeal is pending, your insurer can not reduce or stop coverage for ongoing treatment.

When do I file an internal appeal?

Once you receive notification from your insurer of their decision to deny your claim, you have **180 days** to file an internal appeal. Your insurer must provide notice of a decision to deny your claim within:

- 72 hours for an urgent care claim, as determined by your doctor;
- 30 days for a non-urgent care claim submitted before the service is provided;

- 60 days for a non-urgent care claim submitted after the service is provided; and
- 24 hours for ongoing treatment that the insurer has approved, but is seeking to reduce or stop.

Your internal appeal rights

A full and fair review of your claim's denial is required under the ACA. Your insurer must take steps to preserve the impartiality of decision makers in your appeal.

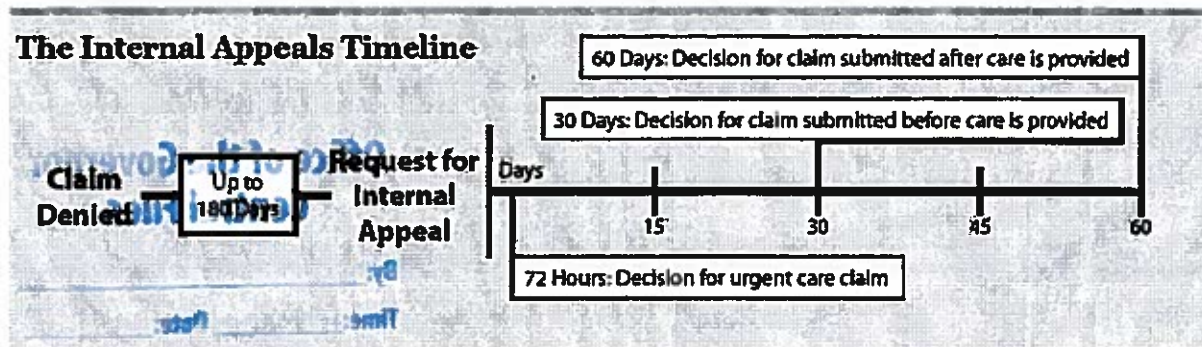
In all internal appeals, your insurer must provide to you free of charge:

- An opportunity to review your claim file and to present evidence or testimony on your behalf;
- Any new or additional evidence considered in your claim before they issue a final decision; and
- A reasonable opportunity to respond to any new information before they issue a final decision.

Once your insurer makes a final decision on your internal appeal, your insurer must provide notice to you that includes:

- Their decision and the rationale behind it;
- Notice of your right to seek external review, including instructions and time limits for filing an appeal; and
- Contact information for the Commissioner of Insurance. The Commissioner can assist you with filing your appeal.

The Internal Appeals Timeline



How it Works: The External Review Process

The federal health care reform law, known as the Affordable Care Act (ACA), ensures you have certain rights if your health insurer denies your claim. These rights make the process of appealing the insurer's decision more transparent, accountable, and fair.

After the internal appeal process has been exhausted, you may request an external review of your insurer's decision to deny your claim. In some cases, the internal appeal does not need to be exhausted.

What is an external review?

An external review is an independent medical review of an insurer's decision that a health care service is experimental, investigational, or not medically necessary. An insurer's decision to rescind your policy is also subject to external review. Medical professionals from an independent review organization (IRO) with no connection to the health plan must conduct the review.

The new rules for external review provided by the ACA and outlined in this document **do not apply** to grandfathered health plans. Generally, plans issued before March 23, 2010, are grandfathered, unless certain benefit changes trigger a loss of grandfathered status. Check with your insurer to see if your plan is grandfathered.

When do I file an external review?

You have **4 months** to file for an external review after you receive notice from your insurer that your internal appeal has been denied.

Once your insurer has received your external review request, they have **5 business days** to determine whether or not your claim is eligible for external review.

Your insurer has **1 business day** after completing this preliminary review to notify you of the results.

If your claim is eligible, your insurer must provide information from your request and their decision within **5 business days** to one of three contracted IROs assigned randomly. Failure to provide complete information before this deadline will result in the IRO ruling in your favor and reversing the claim denial.

You may submit additional information to the assigned IRO within **10 business days**. The IRO may accept additional information from you beyond this 10 day period. The IRO must send any additional information to the insurer within **1 day**.

The IRO must make its final decision within **45 days** of receiving the request from your insurer.

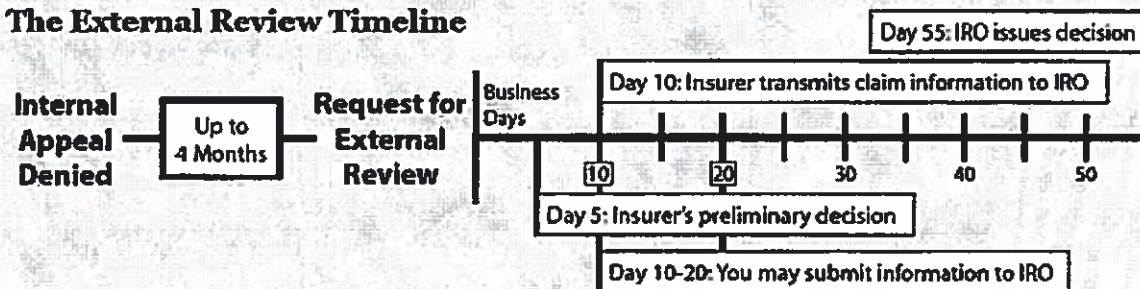
Expedited external reviews are available in cases of urgent medical care, as determined by your doctor. In urgent cases, your insurer must notify you immediately of their decision to deny your internal appeal, then immediately assign an IRO to your claim and transmit all necessary information to the IRO. The IRO must issue its decision within **72 hours**.

Your external review rights

The ACA paved the way for new rules to ensure the IRO charged with reviewing your claim is truly independent. Those rules require that:

- IROs must not receive financial incentives based on the outcome of your claim;
- IROs must have legal experts on staff, in addition to the medical experts reviewing your claim; and
- IROs must conduct a full review of your claim from the beginning without regard for the result of an internal appeal.

The External Review Timeline



Office of the Governor
Central Files

By: EMD
Time: 10:10 Date: 6-8-10